Exhibit E (2 of 3)

Advance Notification

You must notify the plan in advance for certain kinds of healthcare. Advance notification (sometimes referred to as precertification) is designed to help protect you from the cost and inconvenience of unnecessary surgery or extended hospital stays. By calling in advance, you learn before you incur an expense whether your treatment is covered by the plan. In addition, it is important to notify the plan when necessary, or your benefits may be reduced.

You are responsible for notifying the plan by calling UnitedHealthcare toll-free at 1-866-328-6575. You must call whenever a provider recommends hospitalization or nonemergency surgery. For an emergency hospital admission, you (or a family member) must notify UnitedHealthcare within 48 hours (72 hours in New York) of your admission. If you do not call before hospitalization (or if your hospital stay is longer than approved), there is a $500 penalty.

Medical Coverage at Age 65 or Older

At age 65, you become eligible for Medicare. Medicare coverage becomes your primary coverage. You can supplement Medicare with corporation-provided medical coverage by participating in The McGraw-Hill Companies Drug Supplement Plan.

Medicare

Medicare offers two types of coverage: Part A (hospital coverage) and Part B (medical coverage). There is no charge for Part A coverage. However, for Part B, you must apply for coverage and pay a monthly premium. Contact your local Social Security office for an application.

In combination, Medicare Parts A and B help pay charges for hospitalization, care in a skilled nursing facility, home nursing care, doctor's visits, and most other medical expenses except prescriptions.

It's important that you and your spouse enroll in Medicare Part B. You should apply for coverage at least three months before your 65th birthday. If your spouse is under age 65, he or she will continue to be covered by corporation-provided coverage until he or she reaches age 65. At age 65, your other corporation-provided coverage ends. You and your spouse will then be eligible for the Drug Supplement Plan.

The McGraw-Hill Companies Drug Supplement Plan

The McGraw-Hill Companies Drug Supplement Plan, which is administered by Medco Health Solutions, Inc., is available to eligible retirees age 65 and older.

Type of Pharmacy	You Pay	The Plan Pays
Retail pharmacy within the plan's network	20% of the discounted price for up to a 30-day supply of eligible prescription drugs	80% of the discounted price for up to a 30-day supply of eligible prescription drugs
Retail pharmacy outside the plan's network	the full price for your eligible prescription and submit your claim for reimbursement	80% of the amount you paid for your eligible prescription
The plan's mail-order prescription program	20% of the discounted price for up to a 90-day supply of eligible prescription drug	80% of the discounted price for up to a 90-day supply of eligible prescription drugs

Retiree Dental Coverage Options

If you are eligible for retiree healthcare coverage, you can continue the same dental coverage that you had on your last day as an active employee when you retire from the corporation, which was one of the following:

- **The McGraw-Hill Companies Dental Plan**, which covers you regardless of which dentist you use and generally provides a lower level of benefits than the DMO Dental Plan. This plan also offers you access to a network of dentists who will provide care at pre-negotiated fees. Although you are not required to use network providers, your out-of-pocket cost will generally be less if you use dentists in this network than if you use providers who are not in the network.
- **The DMO Dental Plan**, which provides coverage through a network of dentists. In some cases, benefits are higher in the DMO Dental Plan than in The McGraw-Hill Companies Dental Plan. You must use DMO network providers in order to receive benefits from the plan.

See *Dental Coverage* for details on these plans.

If you retired on or after July 1, 2003, you will pay the full cost of the dental coverage you elect, on an after-tax basis. For those who retired before July 1, 2003, the corporation pays a portion of the cost of your coverage, and you pay the balance, on an after-tax basis.

Retiree Vision Coverage Option

If you are eligible for retiree healthcare coverage, retired after 2002, and you were enrolled in the Vision Plan on your last day as an active employee, you can continue that same coverage when you retire from the corporation.

Retirees who elect to participate in the vision plan will pay the full cost of the coverage they elect, on an after-tax basis.

Administered by Vision Service Plan (VSP), the Vision Plan helps you save money on your eye care needs through a nationwide network of vision care professionals. See *Vision Coverage* for more information.

Your medical plan might also include benefits for certain types of vision care. Check the plan summaries at *www.benefitsplanner.com* for details.

Enrolling and Changing Coverage

To receive post-retirement medical, dental, and vision coverage, you must enroll within 31 days of your retirement, and you must make the required contributions. If you do not enroll within 31 days or do not make the necessary contributions, you will not have coverage and will not be able to obtain coverage from the corporation at a later date.

You may cancel coverage at any time. Once you cancel coverage, you may not re-enroll.

If You Have Other Coverage

If you have other coverage available to you—such as through your spouse's employer's plan—as you decide which plan to enroll in, you may wish to compare the benefits and cost of the other plan with the coverage available from the corporation. Also, you may wish to check how the other plan will coordinate benefits with the corporation's plan. For instance, if you are enrolled in Medicare, the corporation's plans pay benefits after you first submit your claims to Medicare. The corporation's plans have a coordination of benefits feature to prevent duplication of payments when you or your family members are covered by another group medical plan, including government coverage such as Medicare or medical coverage under the "no fault" or payment provisions of an automobile insurance contract. For more information, see "If You Have Other Coverage" in *Participating in Healthcare Coverage*.

Paying for Coverage

You pay for retiree medical, dental, and vision coverage with monthly contributions. If you receive a regular pension (ERP) benefit from the corporation, your contributions are deducted from your monthly pension check. If your pension benefit is not enough to cover your contributions, you will need to make payment arrangements. Contact the HRSC for more information.

If you are not receiving a pension from the corporation, you will need to make payment arrangements as described under "Contributions When Not on Payroll" in *Participating in Healthcare Coverage*.

Depending on when you retired, the corporation may or may not share in the cost of your retiree medical and dental coverage. Like active employees, you pay the full cost of retiree vision coverage. Your retiree dental and vision contributions are paid on an after-tax basis as a retiree.

The cost of your retiree medical coverage depends on:

- when you retired,
- your service with the corporation prior to your retirement, and
- the medical option you select and level of coverage you select (self only, self plus one eligible family member, or self plus two or more eligible family members).

The cost of your retiree dental coverage depends on:

- when you retired (whether you retired before July 1, 2003), and
- the level of coverage you select.

The cost of your retiree vision coverage depends on the level of coverage you select.

Contribution rates may be adjusted annually to accommodate changes in the cost of coverage. Each year, you will be notified if there are any changes in the coming year's contribution rates.

Limit on Corporation Contributions

In the early 1990s, the Financial Accounting Standards Board (FASB) issued a new set of accounting requirements called FAS 106, Accounting for Post-Retirement Benefits. FAS 106 required U.S. companies to account for the projected future costs of their retiree healthcare programs in a manner similar to the way corporations account for pensions. At that time, The McGraw-Hill Companies, along with many other U.S. corporations, reevaluated its retiree healthcare plans.

One of the key elements of the redesigned program involved placing a "cap" on the amount the corporation would pay for healthcare coverage. The corporation's contributions would be capped when the amount the corporation was paying equaled two times the amount the corporation was paying in 1993.

We now estimate that this cap will be reached by 2004 for post-65 coverage and by 2005 for pre-65 coverage. Therefore, for employees who retired on or after July 1, 1993, there is a limit on how much the corporation will contribute toward the cost of retiree medical and dental coverage.

- The limit is based the corporation's share of retiree medical and dental costs in 1993.
- When the corporation's share of retiree medical and dental costs reaches two times the amount the corporation was contributing per person in 1993, the corporation's contributions will not increase any further. If retiree medical and dental coverage costs continue to increase, retirees will be responsible for all costs beyond the corporation's contribution.

After the contributions reach this limit, the corporation will continue to contribute toward the cost of coverage, but will not contribute any more than the limit amount. Retirees will be responsible for paying the remainder of the total cost themselves.

If you retired on or after July 1, 1993...

There is a limit on how much the corporation will contribute toward the cost of your retiree medical and dental coverage. When the corporation's share of retiree healthcare costs reaches two times its 1993 cost, you will be responsible for all costs beyond the corporation's contribution. This is expected to happen around 2004.

When Coverage Begins and Ends

Coverage for you and your eligible family members begins on your retirement date, provided you submit your completed application within 31 days of your retirement date. To prevent an interruption in your medical, dental, or vision coverage, you should submit your request at least a month before you retire.

Your retiree healthcare coverage ends on the earliest of the following dates:

- The last day of the month in which you stop making the necessary contributions toward the cost of coverage
- The day the corporation discontinues the plan
- The day you die

Your covered family members' retiree healthcare coverage ends on the earliest of the following dates:

- The last day of the month in which the corporation does not receive the necessary contributions toward the cost of coverage
- The day the corporation discontinues the plan
- The last day of the month in which you no longer meet the eligibility requirements (except in case of your death)
- The last day of the month in which the applicable family member no longer meets the eligibility requirements
- The day the covered family member dies

Please note that the corporation has the right, with or without advance notice, in an individual case or generally, to amend or terminate all or any part of the benefit program, your contributions to it, or those who participate in it, at any time and for any reason, at its discretion, subject to a collective bargaining agreement when appropriate.

Expatriate Healthcare Coverage

If you are a U.S. citizen working outside the United States (an expatriate), your corporation benefits remain the same, with two exceptions:

- Your medical coverage is provided through the Global Choice plan.
- The DMO Dental network does not have providers outside the United States.

In This Section **See Page**

Expatriate Medical Coverage

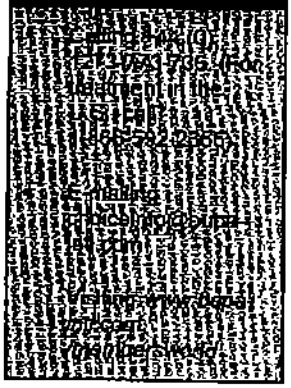
The Global Choice plan, which is a health care alliance between BUPA International and UnitedHealthcare, offers you the special medical coverage you need as an expatriate employee.

If you already have medical coverage through the corporation, you (and any dependents who are currently enrolled) will automatically be enrolled in this special medical coverage for expatriates when you relocate outside the U.S.

If you currently do not have medical coverage through the corporation and want to enroll in this special medical coverage for expatriates, you must do so within 31 days of your assignment date.

How the Global Choice Plan Works

Contact BUPA International and the Global Choice plan by:



The Global Choice Plan offers a network of international healthcare providers and facilities. You have the freedom to see any doctor you wish, but your out-of-pocket costs will typically be lower when you use a provider or facility in the plan's network. To find a network provider, contact BUPA International. You can search for hospitals outside the U.S. that are in the BUPA International hospital network online at *www.bupa-intl.com/membersworld*.

Prior Notification

Before you begin a course of treatment, you should call BUPA International and give the details of the condition for which you are being admitted and the hospital or clinic you wish to use—this is called prior notification.

Medical Repatriation

If you're enrolled in the Global Choice Plan and you have a medical condition that cannot be treated in your current location, the plan will organize transport for you and a companion to return to the U.S. from anywhere in the world. This is called medical repatriation. The plan will make all of your hospital arrangements for you and provide a daily expense allowance to help towards the cost of the companion's stay, should they need it.

If you need emergency treatment but travel to the U.S. would not be medically advisable, the medical repatriation benefit ensures that you will be transferred to the nearest center of medical excellence (if a local facility does not offer the level of care or expertise you need). The associated costs are paid for by the plan and the plan will make all necessary hospital arrangements.

For more information on medical repatriation, call International SOS at +44 (0) 1273-333-911.

Expatriate Dental Coverage

Expatriates can participate in The McGraw-Hill Companies Dental Plan or the DMO Dental Plan. However, the DMO Dental Plan network only includes providers in the United States.

If you're currently enrolled in the DMO Dental Plan and you wish to continue dental coverage as an expatriate, you have two options:

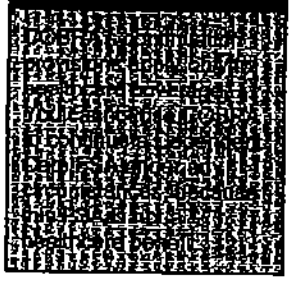
- Continue your current coverage and only seek dental care when you are home in the United States, or
- Change your coverage to The McGraw-Hill Companies Dental Plan.

For more information about The McGraw-Hill Companies Dental Plan, see *Dental Coverage*, and see the plan summary at *www.benefitsplanner.com*. If you want to change from the DMO to The McGraw-Hill Companies Dental Plan, you must do so within 31 days of your assignment date.

COBRA Health Coverage

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you and/or your dependents may be eligible to continue healthcare coverage, at your own expense and on an after-tax basis, when the coverage that you have through the corporation ends.

COBRA and FSAs



In This Section **See Page**

COBRA lets you continue the same health coverage you had before the event that qualified you for COBRA coverage, including:

- medical coverage,
- dental coverage, and
- vision coverage, plus
- Healthcare Flexible Spending Account contributions.

COBRA health coverage continues for up to 18, 29, or 36 months, depending on how you or your family member becomes eligible. See "How Long COBRA Coverage Lasts" in this section.

You pay for whatever COBRA coverage you elect, on an after-tax basis. You decide which of your healthcare coverages to continue, based on your needs. For example, if you are eligible to continue medical and dental coverage under COBRA but have access to medical coverage through your spouse's employer, you might decide to continue only your dental coverage through COBRA.

Coverage for Young Adults

When children you cover under the corporation's healthcare plans lose eligibility for coverage (by getting married, starting full-time work, reaching age 25, etc.) they are eligible to elect COBRA to continue their coverage. See *Dependent Children and Termination of Healthcare Coverage*, for more information on when eligible dependent children lose eligibility.

Eligibility

You may apply for COBRA health coverage for yourself and your covered family members if the healthcare coverage that you have through the corporation would otherwise end because you are no longer eligible (even if you are still an employee of the corporation). One exception applies—you and your covered family members are not eligible for COBRA coverage if you are terminated for gross misconduct.

COBRA continuation is available if your corporation healthcare coverage ends because:

- your hours have been reduced below the minimum to continue coverage,
- your active work status has changed due to your resignation, termination, long-term disability, leave of absence, or retirement, or
- the corporation is subject to a bankruptcy proceeding.

Your covered family members may apply for COBRA health coverage if their coverage would otherwise end because:

- of your death, divorce, or entitlement to Medicare,
- because your dependent child becomes ineligible as a result of reaching age 23, or
- for some other reason.

See "Family Eligibility" in *Participating in Healthcare Coverage* for a description of eligible family members.

Changes in Status

While you are covered through COBRA, you can change your coverage in case of a qualifying change in status, such as your marriage or the birth of a child. You must notify the HRSC within 31 days after the change in status if you want to make a change. If you meet the 31-day deadline, the change in COBRA health coverage will be retroactive to the date of the change in status. For more information on qualifying changes in status, see "After Qualifying Events" in *Participating in Healthcare Coverage*.

Enrolling

In most cases, you will automatically receive an election form and more information about COBRA health coverage if you become eligible for it.

In the case of a divorce or legal separation, or when your covered dependent child loses eligibility, you or the affected individual is responsible for notifying the HRSC within 60 days of the event to request enrollment information and elect COBRA health coverage. You can reach the HRSC toll-free at 1-888-THE-HRSC (1-888-843-4772). The HRSC will contact the COBRA administrator and request the appropriate forms for you.

60-Day Deadline

You must elect COBRA health coverage within 60 days after an event qualifies you for COBRA, or 60 days after the COBRA administrator mails your election form, whichever is later. Remember that you need to notify the HRSC within 60 days if a covered family member becomes eligible for COBRA benefits.

Cost of Coverage

If you elect continued coverage under COBRA, you are required to pay the full cost of the coverage—both the share you paid as an employee and the share that the corporation paid—plus a 2% administrative charge, in most cases. This means that when your coverage changes to COBRA coverage and you begin paying the part previously paid by the corporation, the cost to you can be a lot higher.

If you are disabled as determined by the Social Security Administration, you may continue COBRA coverage for up to 29 months. In this case, your cost for the first 18 months would be 102% of the full cost of the coverage, but would go up to 150% of the full cost for the remaining 11 months.

Your payments for coverage are made on an after-tax basis. You will receive information on how to make payments when you enroll for COBRA coverage.

Payment Deadlines

After you return your COBRA enrollment form, you will have 45 days (counted from the date you return your form) to pay any back premiums necessary to avoid a gap in coverage. The premiums you must pay are retroactive to the date coverage ended under the applicable benefit plan.

If you do not continue to make the scheduled payments for your COBRA coverage on time (within 30 days of the payment due date), your COBRA coverage will be canceled.

Pay on Time

According to the federal rules that govern COBRA coverage, if you fail to make payments for your COBRA health coverage on schedule, your coverage will end. No exceptions will be made, even if your payment is only one day late.

How Long COBRA Coverage Lasts

The length of time COBRA health coverage can last depends on the event that caused your eligibility.

In some states, such as California, coverage can continue longer than it does as described below, under state law. You will be informed of the coverage for which you are eligible.

For 18 Months

COBRA health coverage can continue for up to 18 months if you and/or your covered family members would otherwise lose the health coverage you had through the corporation because of:

- your reduction in hours, or
- your change from active work status due to your:
  - resignation,
  - termination (except for termination for gross misconduct),
  - disability,
  - leave of absence, or
  - retirement.

For 29 Months

COBRA health coverage can continue for up to a total of 29 months if:

- within the first 60 days of COBRA health coverage, you or a family member eligible for COBRA was determined to be permanently disabled according to the Social Security Administration, and
- you or your family member notifies the COBRA administrator before the end of the initial 18-month COBRA period.

For 36 Months

COBRA health coverage for your dependents can continue for up to a total of 36 months from the date any one of the following events occurs:

- Your death
- Your divorce
- Your entitlement to Medicare
- Your family member ceases to be eligible for coverage

If any of these events occurs while a family member is covered under COBRA (because of an 18-month event described previously), COBRA health coverage may be continued for up to a total of 36 months from the date of the first event.

Eligible for Medicare

If you become entitled to Medicare benefits and then lose medical coverage within the next 18 months because you are terminated or your hours are reduced, your covered family members can purchase COBRA health coverage for a maximum of 36 months from the date you became eligible for Medicare.

If You Die

If you die, your covered family members will be offered the opportunity to elect up to 36 months of COBRA health coverage.

COBRA and FSAs

If you become eligible to continue your healthcare benefits under COBRA, you may continue your contributions to your Healthcare Flexible Spending Account (FSA), but only on an after-tax basis and only until the end of the calendar year in which you become eligible for COBRA.

For more information, see "Healthcare FSAs" in the *Flexible Spending Account* section.

When Coverage Ends

COBRA health coverage ends on the earliest of the following:

- When you or your family member becomes covered under another group health plan that does not contain an exclusion or limitation regarding any preexisting condition you or your family member may have (previous coverage that you had under another group health plan, such as through your spouse's employer, will not terminate or affect your right to elect COBRA health coverage)
- When you or your family member becomes entitled to Medicare (usually at age 65)
  - COBRA health coverage (excluding dental coverage) ends only for the person who becomes eligible for Medicare; individuals who are not eligible for Medicare may continue their COBRA health coverage
  - Dental coverage may be continued through COBRA after you become eligible for Medicare
- When you do not make payments when required
- When the corporation health plan is terminated or amended to eliminate coverage and the corporation does not provide a substitute plan to employees
- When the COBRA continuation period – 18, 29 or 36 months—ends
- For after-tax healthcare FSA contributions, at the end of the calendar year in which those after-tax contributions began

Coverage Certificates

When your COBRA health coverage ends, you automatically receive a certificate of coverage confirming that you had whatever medical coverage you continued through COBRA and stating how long you were covered. If you become eligible for other medical coverage that excludes or delays coverage for certain pre-existing conditions, you can use this certificate to receive credit—against the new plan's pre-existing condition limit—for the time you were covered by the corporation's plan.

In addition to the certificate you receive automatically, you also may request a certificate within 24 months after coverage ends.

Flexible Spending Accounts (FSAs)

The corporation offers you the opportunity to contribute to two kinds of flexible spending accounts (FSAs)—a Healthcare Flexible Spending Account and a Dependent Care Flexible Spending Account.

In This Section

Terms to Know

Active Employee

For benefits eligibility purposes, you are considered an active employee if you are receiving a regular paycheck (directly from the corporation) to pay wages for services you are currently providing to the corporation.

Highly Compensated Employee

For plans subject to federal regulations, Internal Revenue Code (IRC) rules define certain employees as "highly compensated." Employees determined to be highly compensated may be subject to special rules that affect their benefits. If your benefits are affected because you are determined to be highly compensated, you will be notified.

To determine whether an employee is highly compensated for the current year, the IRC rules look back at the prior year's compensation.

For your 2004 benefits, you are considered to be a highly compensated employee if your compensation was more than $90,000 in 2003.

Participating in FSAs

FSA Participation Information Only

The information about eligibility and changing your coverage in this section applies to the FSAs only.

For eligibility and participation information regarding the corporation's other benefits, see the separate descriptions of each benefit in this handbook.

The benefits described in this handbook are provided for employees of The McGraw-Hill Companies, Inc. This section explains which employees are eligible to participate in flexible spending accounts (FSAs) and discusses some aspects of your employment that can affect your participation, such as your regularly scheduled work week.

The provisions in this section apply only to the following benefits:

- Healthcare FSA
- Dependent Care FSA

In This Section **See Page**

Employee Eligibility

Ineligible Individuals

Even if you meet the eligibility requirements, you cannot participate if you fall into one or more of the groups listed under "Individuals Not Eligible" in *Rules and Regulations*.

You are eligible to open and contribute to an FSA if:

- you are employed by a corporation business unit that participates in the applicable plan,
- you are an active full-time or an active part-time employee,
- you are regularly scheduled to work at least 20 hours per week, and
- you are employed in the United States, or you are a U.S. employee temporarily working abroad.

If you meet these eligibility requirements when first hired by the corporation, you are eligible as of your hire date. If you do not meet these requirements when first hired, you are not eligible until your employment status changes to meet the eligibility requirements.

Active Employees

The benefit plans described in this handbook are designed primarily for active employees and their eligible family members. Although you may be able to continue participating in some of the plans if your active employment ends (for example, if you go on an approved, unpaid leave of absence), to begin participating you must be considered to be an active employee.

For information on your eligibility to continue participating in a healthcare FSA when you are not an active employee, see "When Contributions End" in *Healthcare FSA*.

Regular Work Schedule

Most of the corporation benefits require that you be regularly scheduled to work 20 or more hours a week to be eligible. For benefits eligibility purposes, your regularly scheduled work week is based on your regular work schedule, not the actual hours you work. If your regularly scheduled work week changes, your eligibility to participate in corporation benefits may change.

Fewer Than 20 Hours

If you are regularly scheduled to work fewer than 20 hours a week or if you are a temporary employee, you are not eligible to participate in the FSAs.

Work in the United States

To be eligible for most of the benefits described in this handbook, you must be working for the corporation in the United States of America (including its territories and commonwealths), or you must be a U.S. employee temporarily working abroad.

Enrolling When First Eligible

You may enroll in an FSA during the 31 days after you become eligible. Contributions are retroactive to your first day of employment. Generally, if you do not submit your decisions about whether and how much to contribute within this 31-day deadline, you cannot open an account until the next annual enrollment period. However, you may have an additional enrollment opportunity if you have a qualifying change in status. See "After Qualifying Events" for more information.

Enrolling During Annual Enrollment

Each year, the corporation holds an annual enrollment period. During this period, you have the opportunity to change your participation in the corporation's benefits for the coming calendar year.

You must re-enroll every year to continue your FSA participation.

After Qualifying Events

The enrollment choices you make when you first become eligible or during annual enrollment are in effect for the entire calendar year for which you enroll.

However, because your needs for benefits typically change when you experience certain family events—such as getting married or having a baby—you are allowed to make changes in some situations, in accordance with federal rules, as long as you make your change within 31 days after the event.

Changes in Status

Various events may qualify you to enroll in or make certain changes to your FSA participation. Generally, the events must affect:

- your eligibility to participate in an FSA under an employer plan (including plans of other employers),
- expense eligibility for you or your eligible family members, or
- cost variations for dependent care.

Examples of qualifying events include:

- a change in your legal marital status, such as your marriage, divorce, or legal separation,

- a change in the number of your eligible dependents, including:
  - the birth or adoption of a child, or
  - the death of your spouse or other benefits-eligible family member.
- a change in your or one of your eligible dependent's employment status (such as starting a new job, terminating employment, going on leave, etc.),
- a change in one of your eligible dependent's eligibility for coverage (for example, when your dependent child reaches the dependent care age limit (age 13) or when your position changes in a way that affects your eligibility), and
- your eligible dependent's loss of coverage from another source.

How to Make Changes

You have 31 days from the date of a qualifying change in status to enroll in or change your participation. (Remember that the only coverages you can change because of changes in status are healthcare coverages, plus your participation in FSAs.) Provided you meet this 31-day deadline, the new coverage you choose begins as of the date of the event—for instance, as of the date of your marriage. To make a change, you must access Employee Self-Service.

Keep in mind that any changes you make to your coverage must be consistent with the change in your status. For instance, if you get married you can change your contribution amount to cover your new spouse's eligible expenses.

How FSAs Work

The Healthcare FSA and the Dependent Care FSA allow you to set aside money from your paycheck on a pre-tax basis (thereby reducing your taxable income) to pay for eligible healthcare and dependent care expenses incurred by you and/or your eligible family members. By using pre-tax money, you lower your taxable income.

After incurring eligible expenses, you submit a claim that is reimbursed from your account(s).

- Your Healthcare FSA claim for eligible expenses is paid in full—up to the amount of your annual healthcare contribution—regardless of how much you have in your Healthcare FSA at the time you submit your claim.
- Your Dependent Care FSA claim for eligible expenses is paid up to your account balance at the time you submit the claim. If you ask to be reimbursed for an expense that is greater than the amount in your Dependent Care account, the excess expense is carried over until you have sufficient funds in your account to cover it during that calendar year.

Customer Service

The FSA Plans are administered by UnitedHealthcare. You can contact UnitedHealthcare by calling toll-free 877-[illegible] and following the prompts to speak with a customer service representative. Additional information is available at myuhc.com.

FSA Accounts Are Not Interchangeable

You may use the money in a Healthcare FSA only to pay for eligible healthcare expenses for yourself and your eligible dependents. The money in a Dependent Care FSA can be used only to pay for eligible dependent day care expenses.

In This Section **See Page**

Tax Savings

Your FSA contributions are automatically deducted from your pay and deposited into your FSA account in equal amounts throughout the year. Contributions are deducted before federal, Social Security and, in most locations, state and local income taxes are withheld. In addition, your contributions are not reported as income on your federal W-2 statement at the end of the year. As a result, an FSA enables you to lower your taxable income and pay less in taxes.

Tax Advantage of a Healthcare FSA

Suppose Doug and Linda, a married couple with two teenagers, have a combined annual income of $40,000. Doug expects to use his $1,500 Healthcare FSA contribution to pay for the family medical copayments, the children's elective contact lenses, and a new dental crown for himself. When they prepare their income tax return, Doug and Linda file jointly and take a standard deduction and four personal exemptions. Here is how they save using a Healthcare FSA.

	Without an FSA	With an FSA
Combined annual income	$40,000	$40,000
Pre-tax Healthcare FSA contribution	- $0	- $1,500
Adjusted gross income	$40,000	$38,500
Estimated federal income tax	- $2,378	- $2,153
Estimated Social Security tax (FICA)	- $3,060	- $2,945
Eligible healthcare expenses	- $1,500	- $1,500
Healthcare FSA claim reimbursement	+ $0	+ $1,500
Net spendable income	$33,062	$33,402
Annual savings		$340

This example was calculated using 2003 tax rates and is for illustrative purposes only. The actual savings that a Healthcare FSA can provide depend on a number of factors, including your salary, tax bracket, the number of personal exemptions you claim, and the tax rates in effect in the year you use an FSA.

Tax Advantage of a Dependent Care FSA

Suppose Darlene works for the corporation, her husband Wayne works for another employer, and they have a combined annual income of $68,000. Darlene contributes $5,000 to the corporation's Dependent Care FSA to help pay the $400 weekly fee for their two preschoolers to attend a day care center. (According to federal tax regulations, the maximum amount an employee can contribute to a dependent care FSA for a married couple filing jointly is $5,000.) Since Darlene has contributed to the Dependent Care FSA at the $5,000 maximum contribution level, Wayne cannot contribute to his employer's dependent care FSA program.

When they prepare their income tax return, Darlene and Wayne file jointly and take a standard deduction and four personal exemptions. Here is how they save using the Dependent Care FSA.

	Without an FSA	With an FSA
Combined annual income	$68,000	$68,000
Dependent Care FSA contribution	- $0	- $5,000
Adjusted gross income	$68,000	$63,000
Estimated federal income tax	- $6,626	- $5,828
Estimated Social Security tax (FICA)	- $5,202	- $4,820
Out-of-pocket costs for dependent care expenses (52 weeks @ $400 per week)	- $20,800	- $20,800
Dependent Care FSA claim reimbursement	$0	+ $5,000
Net spendable income	$35,372	$36,552
Annual savings		$1,180

This example was calculated using 2003 tax rates and is for illustrative purposes only. The actual savings that a Dependent Care FSA can provide will depend on a number of factors, including your salary, tax bracket, the number of personal exemptions you claim, and the tax rates in effect in the year you use an FSA.

Estimating Expenses

Be sure to estimate your healthcare and dependent care expenses carefully. First, review the healthcare expenses you typically have during a year. Then, using the "Healthcare FSA Worksheet" and the "Dependent Care FSA Worksheet" at *www.benefitsplanner.com*, carefully estimate the dollar amount that you expect to incur over the year for those expenses. Use that as a guide to determine how much you want to direct from your pay into a Healthcare FSA and/or Dependent Care FSA.

Impact on Other Benefits

Even though you reduce your taxable income by participating in an FSA, your contributions do not reduce your pay with regard to any of the corporation's pay-related benefits, such as disability, life insurance, and retirement. Those benefits are based on your gross earnings before any FSA deductions.

Pre-tax contributions to an FSA will, however, reduce your income for Social Security purposes. As a result, if you earn less than the Social Security wage base ($87,900 in 2004), your Social Security taxes will be lower, and this may reduce the benefit you would receive from Social Security at retirement.

The effect on your Social Security benefits depends on a number of factors, such as your age, your earnings before contributing to an FSA, and future pay levels. In many cases, the current income tax savings gained from contributing to an FSA outweigh the increase in Social Security benefits that would be gained by not contributing to one.

Forfeiting Unused Balances

Keep in mind that in exchange for the tax savings you receive when you participate in an FSA, the IRS requires that you forfeit any contributions remaining in your account after you have filed all your claims for the calendar year. This means that if you don't use the money in your account, you lose it.

In addition, be aware that:

- You cannot use the balance in your Healthcare FSA to:
  - pay for expenses eligible for reimbursement under a Dependent Care FSA,
  - receive a refund, or
  - fund an FSA for the following year.
- You cannot use the balance in your Dependent Care FSA to:
  - pay for expenses eligible for reimbursement under a Healthcare FSA,
  - receive a refund, or
  - fund an FSA for the following year.

You have until March 31 of the following year to submit claims for eligible expenses incurred through December 31 of the previous year. For example, you have until March 31, 2005 to submit claims for expenses incurred during 2004.

Healthcare FSA

The Healthcare Flexible Spending Account (FSA) gives you the opportunity to reduce your taxes and lower your costs for certain healthcare expenses, and increases your spendable income. You can set aside money from your salary before taxes are calculated and then use those funds to reimburse yourself for eligible healthcare expenses you and your eligible family members incur.

In This Section **See Page**

How Much You May Contribute

You can set aside up to $5,000 per full calendar year in the Healthcare FSA (with an annual minimum of $50).

Your contribution is automatically deducted from your pay on a pre-tax basis and redirected into your account in equal amounts throughout the year.

Mid-Year Enrollments

If you open an FSA in the middle of the calendar year—for instance, if you are a new employee or if you have experienced a qualifying change in status—the amount you can contribute for the remainder of the calendar year is a prorated portion of the amount you could have contributed for the full calendar year, subject to all of the limitations described previously.

For example, if you do not open an account until July 1, you would be permitted to contribute only $2,500 (half of the $5,000 allowed per full calendar year) over the remaining half of the year.

What Your Healthcare FSA Can Pay For

For the purposes of the Healthcare FSA, the people whose expenses are eligible for reimbursement are:

- you,
- persons you claim as dependents on your federal income tax return (whether or not they are eligible for, or covered by, any of the corporation's healthcare plans), and
- dependent children who do not live with you, if you are legally required to pay their healthcare expenses.

You may not use a Healthcare FSA for reimbursing healthcare expenses incurred by a former spouse.

If you have a domestic partner, keep in mind that you may use a Healthcare FSA to reimburse yourself for your partner's eligible expenses only if he or she is your tax dependent.

Eligible Expenses

With one exception, any healthcare expenses that would be deductible on your federal income tax return (excluding insurance premiums) are eligible for Healthcare FSA reimbursement, as long as you do not take a tax deduction for the same expenses and you are not reimbursed for them in any other way. The exception is that expenses for long-term care are not eligible for FSA reimbursement, even though long-term care costs are tax deductible.

Expense Information

The expenses that are eligible for reimbursement under the Healthcare FSA include most of those eligible for federal income tax deduction (excluding long-term care expenses). You can find more examples of eligible expenses by referring to IRS Publication 502, *Medical and Dental Expenses*. Publication 502 is available at your local IRS office or on the IRS Web site, www.irs.gov. Publication 502 may include references to medical savings accounts, or MSAs. MSAs are not the same as FSAs.

Examples of eligible healthcare expenses include:

- any healthcare deductibles, coinsurance, and copayments incurred by you or your eligible family members,
- healthcare expenses for persons you claim as dependents on your federal income tax return (whether or not they are eligible for, or covered by, any of the corporation's healthcare plans),
- healthcare expenses for dependent children who do not live with you, if you are legally required to pay their healthcare expenses, and
- other expenses not currently covered by the corporation's healthcare plans, such as
  - hospital charges for a private room (above the average charge for a semiprivate room) and
  - vision care expenses provided by doctors and eyewear facilities outside the Vision Service Plan's network, expenses that exceed the Vision Service Plan's maximums, or expenses for noncovered items.

Starting January 1, 2004, you can use your Healthcare FSA to cover the cost of over-the-counter drugs that you purchase to treat illness or injury. You can't use your FSA for over-the-counter drugs that are for general well-being (such as vitamins), but if you purchase a medication such as Claritin for allergies or buy cold medication because you are sick, those expenses are eligible for FSA reimbursement. Just remember that when you file your claim you will have to include a receipt that shows the date of purchase, the name of the drug, and the cost of that drug.

Additional healthcare expenses that are eligible for reimbursement from your Healthcare FSA include the following:

- Acupuncture
- Abdominal supports
- Air conditioner where necessary to relieve allergies or breathing difficulties
- Artificial limbs
- Back supports
- Birth control pills or other doctor-prescribed birth control items

- Braille books (that is, the excess cost of Braille books over the cost of regular editions)
- Christian Science practitioner
- Contact lenses and lens replacement insurance
- Cosmetic surgery (to improve a deformity associated with a congenital abnormality, accident- or trauma-induced personal injury, or disfiguring disease)
- Elastic hosiery for medical purposes
- Fluoridation unit in your home
- Guide dogs
- Hearing expenses, such as hearing exams, hearing aids, and batteries
- Home modifications to accommodate a person with a disability
- Nursing services
- Orthopedic shoes and arches
- Remedial reading instruction for a dyslexic child
- Sacroiliac belts
- Sanitariums and similar institutions
- Smoking cessation programs (excluding nonprescription drugs)
- Special equipment for deaf persons (TV adapter/telephone-teletype)
- Special mattresses and plywood bed boards for relieving spinal arthritis
- Special schools for handicapped children
- Sterilization procedures for birth control
- Trusses
- Weight loss programs prescribed by a doctor for treating diseases such as hypertension and/or obesity

Tax Deductions for Unreimbursed Healthcare Expenses

You can either use a healthcare FSA or claim the medical expense deduction on your tax return for expenses not covered by your healthcare plan. You cannot use a healthcare FSA and claim a healthcare tax deduction in the same year for the same healthcare expenses. For any given healthcare expense, you can either

- be reimbursed through your Healthcare FSA, or
- deduct the expenses on your tax return. (Note that you can only deduct healthcare expenses that exceed a certain percentage of your income. Generally, this means that only people with very high medical expenses are able to take this deduction.)

Ineligible Expenses

Some expenses are not eligible for reimbursement from your Healthcare FSA, such as expenses for the following:

- Antiseptic diaper services
- Athletic club services for physical fitness
- Bottled water bought to avoid drinking fluoridated tap water

- Contributions to a medical plan offered by your spouse or partner's employer
- Cosmetic surgery to improve personal appearance
- Deductions from your wages for sickness insurance under state law
- Domestic help, even if recommended by a doctor
- Funerals, cremations, burials, cemetery plots, monuments, and/or mausoleums
- Health programs offered by resort hotels, health clubs, and gyms
- Hair transplant operations
- Illegal operations and drugs
- Long-term care expenses and insurance premiums
- Marriage counseling
- Maternity clothes
- Premiums for other coverage, including COBRA and Medicare premiums
- Pre-tax contributions for healthcare coverage
- Scientology fees
- Vitamins and other nutritional supplements
- Weight loss programs undertaken for general health, not for a specific ailment (see the listing of "Eligible Expenses" for comparison)

Filing a Claim

Each year in the fourth quarter you receive a statement showing your balance and any payments made from your account.

You need to file a claim to be reimbursed through your Healthcare FSA for eligible expenses. You must include proof of payment—a receipt, itemized bill, canceled check, or Explanation of Benefits (EOB)—with your claim. (An EOB is a statement attached to the payment check that details the reimbursed healthcare expenses.) You will not be reimbursed without proper documentation.

The plan reimburses you in full—up to the amount of your annual Healthcare FSA elected contribution—regardless of how much you have in your account at the time you submit your claim. You have until March 31 of the following year to submit claims for eligible healthcare expenses incurred through December 31 of the previous year. You may be reimbursed only for healthcare expenses incurred while you are contributing to the Healthcare FSA.

Claim forms are available:

- at *myuhc.com*,
- on The McGraw-Hill Companies Intranet,
- on the Web at *www.benefitsplanner.com*,
- from the HRSC, and
- from UnitedHealthcare at 1-877-211-6551.

Claim forms must be submitted to the FSA administrator along with a provider statement with cost, dates of service, and services rendered, to the address listed on the form. The FSA administrator reviews your claim and reimburses you for all eligible expenses. If you submit an ineligible claim, you will be notified. Otherwise, you will receive your reimbursement check within one to two weeks.

If you are not satisfied with the outcome of a claim you have submitted for benefits, you can ask that the claim be reviewed. See "Claims Review Process" in *Rules and Regulations* for information.

Automatic Reimbursement

If you are enrolled in the UnitedHealthcare POS plan or The McGraw-Hill Companies Medical Plan and have enrolled for a Healthcare FSA account, any eligible medical claims will automatically be submitted to the FSA Unit for processing after they have been reviewed by the Medical Claims Unit. You will not need to file a separate claim.

Leaving the Corporation

You can submit claims for eligible healthcare expenses incurred before your employment ends through March 31 of the year following the year for which you established the FSA. You may not submit claims for healthcare expenses incurred after you leave the corporation unless you continue making contributions through COBRA.

If You Continue Participating Through COBRA

You can submit claims for eligible healthcare expenses incurred after your employment ends only if you continue participating in the Healthcare FSA. Remember, you can file claims through March 31 of the following year for expenses incurred during the calendar year. For more information, see *COBRA Health Coverage*.

Customer Service Information

You can call the FSA Customer Service Unit at [illegible] if you are calling Monday through Friday from 8:00 a.m. to 5:00 p.m. Eastern Time, at 877-211-0555 for questions about your account or claims status.

By calling this toll-free number, you can also activate the automated voice response (AVR) system to obtain immediate information about your account balance and most recent payment. The AVR system is available Monday through Saturday from 8:00 a.m. to 2:00 a.m. Eastern Time.

When Contributions End

Your pre-tax contributions to your FSA stop whenever the first of the following events occurs:

- The calendar year for which you have elected to participate ends.
- You retire or otherwise end your employment (whether voluntarily or involuntarily).
- You take a leave of absence, including a leave under the Family and Medical Leave Act of 1993 (FMLA).
- You no longer meet the eligibility requirements to participate (for example, if your regular work schedule is reduced to fewer than 20 hours a week).
- The corporation discontinues the plan.
- You die.

Contributing During FMLA Leave

For details about FSA contributions during an FMLA leave, see "Continuing Contributions – FMLA".

If your participation in the Healthcare FSA ends, for example, because your employment ends, you will not necessarily forfeit your account balance. You may be eligible to continue making contributions to the Healthcare FSA on an after-tax basis through the end of the calendar year under the provisions of COBRA. If you have a significant balance in your account, continuing to make contributions can give you time to incur eligible expenses and file claims to be reimbursed, rather than forfeiting the account balance. See "Continuing Contributions—COBRA" for more information.

Continuing Contributions—FMLA

Under the Family and Medical Leave Act of 1993 (FMLA), you may be able to continue participating in the Healthcare FSA when your participation would otherwise end. The FMLA gives you three options if you are contributing to a Healthcare FSA when you begin an unpaid FMLA leave. You may either:

- prepay your contributions for the calendar year in which your leave begins, on a pre-tax or after-tax basis,
- continue your participation (that is, continue making contributions to your FSA on a pay-as-you-go basis) on a after-tax basis, or
- suspend your participation (that is, make no contributions) while you are out on leave and resume participation when you return to work.

Keep in mind, if you suspend your participation while you are out on leave,

- you are not eligible to be reimbursed for expenses incurred during the suspension, and
- your annual contribution election will be prorated to reflect the period during which you were out on leave.

If you continue to participate in the Healthcare FSA while you are on an FMLA leave and you do not return to work at the end of your leave, you may continue your participation on an after-tax basis through COBRA, as described in "Continuing Contributions—COBRA."

Continuing Contributions—COBRA

If you become eligible to continue your healthcare benefits under COBRA (see *COBRA Health Coverage*), you may continue your contributions to your Healthcare FSA, but only on an after-tax basis and only until the end of the calendar year in which you become eligible for COBRA. Even though you would not realize the tax advantages of pre-tax contributions, this may be a good strategy for you if your balance is significantly higher than the eligible expenses you have already incurred. By continuing to contribute on an after-tax basis through COBRA, you could give yourself more time to incur eligible healthcare expenses—such as purchasing a new pair of eyeglasses—so that you could use up the pre-tax balance you had already contributed. (Remember that you may file claims only for eligible expenses that were incurred while you were contributing.)

For information on the terms and conditions of COBRA, see *COBRA Health Coverage*.

Dependent Care FSA

The Dependent Care Flexible Spending Account (FSA) gives you the opportunity to reduce your taxes and lower your costs for certain dependent care expenses, and increase your spendable income. You can set aside money from your salary before taxes are calculated and then use those funds to reimburse yourself for eligible dependent care expenses.

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How Much You May Contribute

You can set aside up to $5,000 per full calendar year in the Dependent Care FSA (with an annual minimum of $50).

Your contribution is automatically deducted from your pay on a pre-tax basis and redirected into your account in equal amounts throughout the year.

Note that if you are defined by the IRS as being "highly compensated," your contributions to the Dependent Care FSA may be limited, depending on the participation of lower-paid employees. If employee participation doesn't reach certain federal benchmarks, your contributions may be restricted. You will be notified if you are affected by these limits.

If you are a highly compensated employee...

your contributions to the Dependent Care FSA may be limited, depending on the participation of lower-paid employees. If employee participation doesn't reach certain federal benchmarks, your contributions may be restricted. You will be notified if you are affected by these limits.

If You Are Married

The IRS places certain limits on how much married couples can contribute to Dependent Care FSAs, as follows:

- If you and your spouse file separate income tax returns, you can contribute up to $2,500 per full calendar year to the corporation's Dependent Care FSA. If your spouse's employer has a dependent care FSA program, your spouse can also contribute up to $2,500 to that program, subject to any other limits that his or her employer's program applies.
- If you and your spouse file a joint tax return, the combined contributions the two of you make to dependent care FSAs cannot be more than $5,000 per full calendar year. In other words, if your spouse contributes $2,000 to his or her employer's dependent care FSA, you can contribute up to $3,000 to the corporation's Dependent Care FSA.
- The combined contributions that you and your spouse make to dependent care FSAs cannot be greater than your or your spouse's earned income, whichever is lower.

- If your spouse does not work, you can only use an FSA to be reimbursed for dependent care expenses if your spouse is disabled or is a full-time student for at least five months during the year. To determine your spouse's earned income in either of these situations, the IRS assumes that your spouse has a monthly income of $250 if you have one dependent, or $500 if you have two or more dependents.

Mid-Year Enrollments

If you open an FSA in the middle of the calendar year—for instance, if you are a new employee or if you have experienced a qualifying change in status—the amount you can contribute for the remainder of the calendar year is a prorated portion of the amount you could have contributed for the full calendar year, subject to all of the limitations described previously.

For example, if you are not married and would be eligible to contribute $5,000 per full calendar year, but you do not open an account until July 1, you would be permitted to contribute only $2,500 (half of the $5,000 allowed per full calendar year) over the remaining half of the year.

The Federal Tax Credit

The IRS permits you to claim a tax credit for dependent care expenses. The federal tax credit allows you to deduct a percentage of eligible expenses from your taxes—for 2003, up to $3,000 for one dependent and $6,000 for two or more dependents.

However, you cannot claim a tax credit for dependent care expenses that are also reimbursed through your Dependent Care FSA. In addition, the reimbursements you receive from your Dependent Care FSA reduce—dollar for dollar—the amount that can be taken as the federal tax credit. Therefore, carefully evaluate which tax-savings approach is better suited to your situation.

Because the 2003 tax credit for two or more dependents ($6,000) is higher than the maximum tax-free reimbursement through the Dependent Care FSA ($5,000), you may be able to use qualified expenses over the FSA threshold toward the federal tax credit.

Dependent Care FSA vs. the Federal Tax Credit

Whether you should use the Dependent Care FSA or the federal tax credit for dependent care expenses depends on your individual situation, and other factors as your income, your marital and filing status, the amount of eligible expenses you incur, and the number of eligible dependents you have. You may want to check with a tax advisor before making your final decision.

What Your Dependent Care FSA Can Pay for

Divorced or Separated?

Keep in mind that you can use a Dependent Care FSA to be reimbursed for child care expenses only if you have custody of the child for a longer part of the year than the other parent.

The Dependent Care FSA allows you to reimburse yourself for certain expenses you incur in caring for eligible dependents. Eligible dependents for purposes of the Dependent Care FSA are different from those eligible for most other corporation benefits, including the Healthcare FSA.

According to the IRS, the dependents whose expenses are eligible for reimbursement through a Dependent Care FSA are defined as follows:

- Children under age 13 whom you can claim as dependents on your federal income tax return
- A disabled spouse who is physically or mentally incapable of self-care
- Any other persons whom you can claim as dependents on your federal income tax return and who are physically or mentally incapable of caring for themselves

For adults to qualify as dependents, they must spend at least eight hours a day in your home.

A New Teenager in the Family?

Remember, once your child turns 13 (unless he or she is physically or mentally incapable of self-care), he or she is no longer eligible for reimbursement under the Dependent Care FSA, and you may want to change your contribution. Your child's loss of dependent eligibility counts as a qualifying change in status, and gives you the opportunity to change your contributions (see *Making Changes* for more information about qualifying events). See *Participating in FSAs* for more information.

Eligible Expenses

Expenses relating to certain household and dependent care services are eligible for reimbursement through your Dependent Care FSA if those services qualify under IRS rules and:

- they allow you (and your spouse, if you are married) to work or look for work,
- your spouse attends school full time, or
- your spouse is disabled.

These include expenses for the following:

- Licensed nursery schools and day care centers for preschoolers, as well as summer day camps for children under age 13 (Schools and centers must comply with state and/or local laws and receive a fee for their services.)
- Services from persons who provide day care in or outside your home, except when the provider is your dependent or your child under age 19
- Day care centers that provide nonresidential day care for dependent adults
- Household services related to the care of an elderly or disabled adult who lives with you
- FICA and other taxes you pay on behalf of a day care provider

Expense Information

Because the expenses that are eligible for reimbursement under the Dependent Care FSA are the same as those eligible for the federal tax credit, you can also get more examples of eligible expenses by referring to IRS Publication 503, *Child and Dependent Care Expenses*. Publication 503 is available at your local IRS office or on the IRS Web site, www.irs.gov.

Ineligible Expenses

Some expenses are not eligible for reimbursement through your Dependent Care FSA, such as the following:

- The cost for any person caring for your child when either you or your spouse is not working or looking for work, unless your spouse is a full-time student or is disabled
- Child support payments
- Expenses applied toward the federal tax credit
- Kindergarten fees
- Babysitting fees to enable you to make doctor's visits
- Overnight camps
- Instructional day programs, such as sports-related camps
- Education, including summer school for the first grade and above
- Convalescent nursing home for a dependent

- Adoption or day care search agencies
- Transportation
- Food, clothing, and entertainment
- Healthcare expenses incurred by your dependents

Finding Dependent Care Providers

In addition to offering the Dependent Care FSA as a way to save on dependent care costs, the corporation also has a resource you can use to find dependent care. ValueOptions at 1-800-544-8320 can give you information on the dependent care providers in your area (both child care and elder care). ValueOptions can also provide helpful ideas on how you can decide which dependent care provider best meets your needs. This information and referral service is free to active employees.

Filing a Claim

Each year in October, you receive a statement showing your balance and any payments made from your account.

You need to file a claim to be reimbursed through your Dependent Care FSA for eligible expenses. You must include proof of payment—a receipt, itemized bill, or canceled check—together with the tax identification or Social Security number of the dependent care service provider when you file your claim. You will not be reimbursed without proper documentation.

The plan reimburses you with money available in your account, up to your account balance at the time you submit a claim. If there isn't enough money in your account to cover your expenses, the excess expenses are carried over until you have sufficient funds in your account during that calendar year. You have until March 31 to submit claims for eligible dependent care expenses incurred through December 31 of the previous year.

Claim forms are available:

- at *myuhc.com*,
- on The McGraw-Hill Companies Intranet,
- on the Web at *www.benefitsplanner.com*,
- from the HRSC at 1-888-THE-HRSC (1-888-843-4772), and
- from UnitedHealthcare at 1-877-211-6551.

Claim forms with receipts must be submitted to the FSA administrator at the address listed on the form. The FSA administrator reviews your claim and reimburses you for all eligible expenses. If you submit an ineligible claim, you will be notified. Otherwise, you will receive your reimbursement check within one to two weeks.

If you are not satisfied with the outcome of a claim you have submitted for benefits, you can ask that the claim be reviewed. See "Claims Review Process" in *Rules and Regulations* for information.

Customer Service Information

You can call the FSA Customer Service Center and speak with a representative Monday through Friday from 8:00 a.m. to 5:00 p.m., Eastern Time, at 1-877-213-6551 for questions about your account or claims status.

By calling this toll-free number, you can also activate the automated voice response (AVR) system to obtain immediate information about your account balance and most recent payment. The AVR system is available Monday through Saturday from 8:00 a.m. to 2:00 a.m., Eastern Time.

Leaving the Corporation

If you leave the corporation, you can submit claims for eligible dependent care expenses incurred through December 31 of the year in which your employment ends—even if the expenses are incurred after you leave. You have until March 31 to submit claims for eligible expenses incurred through December 31 of the previous year.

When Contributions End

Your pre-tax contributions to your FSA stop whenever the first of the following events occurs:

- The calendar year for which you have elected to participate ends.
- You retire or otherwise end your employment (whether voluntarily or involuntarily).
- You take a leave of absence, including a leave under the Family and Medical Leave Act of 1993 (FMLA).
- You no longer meet the eligibility requirements to participate (for example, if your regular work schedule is reduced to fewer than 20 hours a week).
- The corporation discontinues the plan.
- You die.

Unlike the Healthcare FSA, you cannot continue contributing to a Dependent Care FSA on an after-tax basis while you are on a leave of absence under the FMLA, or through COBRA. The Dependent Care FSA is not eligible for FMLA or COBRA continuation.

Dependent Care FSA

Disability Insurance Plans

The McGraw-Hill Companies disability benefits are designed to continue a portion of your pay if an illness, injury or other serious medical condition prevents you from working.

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The corporation's short-term disability coverage is provided through the Salary Continuation and Accident and Sickness Plan (the STD Plan). This plan provides benefits that continue all or a portion of your income for up to 26 weeks if you are disabled, as defined by the STD Plan, by an illness, injury, or pregnancy that prevents you from working. If you are an eligible employee, you are automatically covered by the STD Plan, at no cost to you.

The corporation's Long-Term Disability Plan (the LTD Plan) provides you with income if you are totally disabled as defined by the LTD Plan for more than 26 weeks (the period covered by the STD Plan). The LTD Plan offers basic coverage, which is provided at no cost to you, and supplemental coverage, which you may purchase for additional disability protection.

You may be eligible for Worker's Compensation insurance benefits if you have a job-related disability, and for Social Security disability benefits, whether or not your disability is job-related. If you are eligible for benefits under either of these programs, they will reduce or offset benefits you receive under the corporation's disability plans.

This section describes all the plans and policies relating to continuing your income in case of disability.

Terms to Know

Here are the definitions of some key terms as they are defined by the disability plans, which you will need to understand as you refer to the information in this section. Other plans may have different definitions for these or similar terms.

Compensation

For purposes of the STD Plan, your compensation is as follows:

- For most employees—your current pay rate including any shift differential pay.

- For employees paid on a commission or targeted-income basis—the guaranteed salary or draw you are earning when you become disabled. However, an amount that recognizes incentive or planned additional compensation lost during short-term absences also will be credited according to provisions outlined in the Sales Arrangement and/or Additional Compensation Plan. This credit is calculated as if you were producing at quota or goal during your absence.
- For newly hired employees working on a commission-only basis—the first year's planned and/or estimated compensation, as determined by your manager.

For purposes of the LTD Plan, your compensation is as follows:

- For most employees—your current pay rate plus short-term incentive compensation, overtime, and shift differential pay for the prior calendar year, up to a total maximum compensation of $360,000 per year.
- For employees paid on a commission or targeted-income basis—your salary/draw plus planned additional compensation, plus any overtime pay you received in the prior year, up to a total maximum compensation of $360,000 per year. Calculations are made as if you were producing at quota or goal during your absence.
- Note that the maximum compensation considered under the LTD Plan is $360,000 per year.

Continuous Service—STD Plan and Retiree Healthcare and Life Insurance Benefits

For purposes of the Short-Term Disability (STD) Plan and for retiree healthcare and life insurance benefits, a year of continuous service is a period of 12 consecutive months. Years of continuous service are measured starting with your date of employment, and counting one additional year with each anniversary of that date. (Special rules may apply if you joined the corporation through a merger, acquisition, or other organizational transaction.)

If you go on an approved leave of absence, the period of your approved leave, disability leave, or military or other leave authorized under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) will be counted in determining your years of continuous service.

Disabled

For purposes of the STD Plan, you are considered disabled if you are unable to perform the material duties of your job because of a physical or mental impairment that is not job related and you are under a physician's care. For the Long-Term Disability (LTD) Plan, see the definition of "Totally Disabled."

Totally Disabled

For purposes of the LTD Plan, you are considered totally disabled if you are under the care of a physician and you meet the following requirements:

- During the 26-week period before long-term disability benefits begin and the next 24 months of your disability, you are unable to perform the material and substantial duties of your own occupation (as it is performed in the national economy) before your disability began, due to an injury or sickness.
- After you have received long-term disability benefits for 24 months, you are unable to perform, with reasonable continuity, the material and substantial duties of any occupation for which you are, or reasonably could become, qualified based on your training, education, experience, age or physical and mental capacity, due to an injury or sickness.

For the STD Plan, see the definition of "Disabled."

Participating in the Disability Plans

The corporation's short-term disability coverage is provided through the Short-Term Disability (STD) Plan. If you are an eligible employee, you are automatically covered by the STD Plan at no cost to you.

The corporation's Group Long-Term Disability (LTD) Plan can provide you with income if you are totally disabled as defined by the plan for more than 26 weeks. The LTD Plan offers basic coverage, which is provided at no cost to you, and supplemental coverage, which you may purchase for additional disability protection.

Can I enroll my family members for disability coverage?

No. The corporation's disability plans are designed to replace your income as an employee if you cannot work. They do not include provisions for covering family members who are not corporation employees.

Eligibility and Enrolling

You are eligible for the STD Plan and for the LTD Plan if

- you are employed by a corporation business unit that participates in the applicable plan,
- you are an active full-time or an active part-time employee,
- you are regularly scheduled to work at least 20 hours per week, and
- you are employed in the United States, or you are a U.S. employee temporarily working abroad.

Ineligible Individuals

Even if you meet the eligibility requirements, you cannot participate if you fall into one or more of the groups listed under "Individuals Not Eligible" in *Rules and Regulations*.

If you meet these eligibility requirements when first hired by the corporation, you are eligible as of your hire date. If you do not meet these requirements when first hired, you are not eligible until your employment status changes to meet the eligibility requirements.

You are automatically enrolled in the STD Plan and for basic coverage under the LTD Plan as of the first day you are eligible; you do not need to fill out any forms to participate.

LTD Evidence of Insurability

Depending on when you enroll for supplemental LTD coverage, you may have to provide evidence of insurability.

- If you enroll within 31 days of becoming eligible for the LTD Plan, you can enroll for supplemental coverage without providing medical evidence of insurability.
- If you enroll more than 31 days after becoming eligible for the LTD Plan, you must provide evidence of insurability, which is subject to insurance company approval, before you will receive coverage. Providing evidence of insurability may include completing a medical questionnaire and/or having a physical evaluation. The corporation pays the cost of obtaining this evidence, including the cost of the physical examination.

Paying for Coverage

The corporation pays the full cost of your STD and basic LTD coverage. If you enroll for supplemental LTD coverage, you pay for your coverage through after-tax payroll deductions. The premium is based on the amount of your supplemental benefit as a percentage of your eligible compensation.

Other Disability Coverage

In addition to the coverage available under the corporation's STD Plan and the LTD Plan, most employees have coverage from Workers' Compensation and Social Security. You may be eligible for Workers' Compensation insurance benefits if you have a job-related disability, and for Social Security disability benefits whether or not your disability is job-related. If you are eligible for benefits under either of these programs, they will reduce or offset benefits you receive under the corporation's disability plans.

Short-Term Disability Coverage

If you are disabled, the corporation provides short-term disability coverage through the Short-Term Disability (STD) Plan, which includes the Salary Continuation portion and the Accident and Sickness portion. The STD Plan provides benefits that continue your income for up to 26 weeks if you are disabled, as defined by the STD Plan, by an illness, injury, or pregnancy that prevents you from working.

If you are an eligible employee, you are automatically covered by the STD Plan, at no cost to you.

Defined Terms

Because you are familiar with the definitions of the terms used in this summary, such as Disabled and Compensation, see Terms to Know Not Used Frequently for Disability Insurance Plans.

In This Section **See Page**

How the STD Plan Works

If You Live in California...

State regulations allow STD payments to continue to the length of your disability, up to 52 weeks. After 26 weeks, these payments are coordinated with any benefits payable under the Long-Term Disability Plan. See Long-Term Disability Coverage for more information on how the plans work.

If you are disabled as defined by the STD Plan, the STD Plan provides you with income for up to 26 weeks if you are out of work due to:

- an illness or injury that is not related to your job, or
- your pregnancy.

The STD Plan has two parts that work together to provide your STD benefits:

- The Salary Continuation portion pays benefits first when you are away from work due to a disability.
- The Accident and Sickness portion picks up where the Salary Continuation portion leaves off, if your disability continues.

You will be asked to provide medical evidence of your disability. You may be required to have a medical examination by a physician approved by the corporation. If required, this examination is provided at the corporation's expense.

The benefits you receive from the STD Plan are taxable. This means all income and Social Security (FICA) taxes are withheld from your benefits payment.

Any scheduled pay increase that would become effective while you are disabled is deferred until you return to work.

The STD Plan is considered a payroll practice and is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

The Salary Continuation Portion

Salary Continuation Information

For more information on the Salary Continuation portion and STD benefits, contact the HRSC at 1-888-THE-HRSC (1-888-843-4772).

The Salary Continuation portion generally begins to pay benefits the first day you are absent from work because you are disabled.

Provided that you continue to be disabled as defined by the STD Plan, the Salary Continuation portion pays 100% of your compensation for a period of time that is determined by your continuous service with the corporation on the day before your disability began. Your benefits under the Salary Continuation portion are shown in the following table.

How the Salary Continuation Portion Works

If Your Continuous Service Is...	You Receive 100% of Your Compensation for up to...
fewer than 5 months	2 weeks
5 months or more but less than 4 years	4 weeks
4 years or more	6 weeks, plus 2 additional weeks for each additional year of continuous service after 4 years, to a maximum of 26 weeks

Calculating Absences

When calculating the length of time for which you can receive 100% of your compensation, all your absences during the current calendar year up to the first day you are disabled are counted against the total time period for which you are eligible to receive 100% of your compensation. In addition, the period for which you are eligible to receive 100% of your compensation depends on your continuous service the day before your disability began. This provision may affect you if you have a recurring disability, as described under "Recurring Disabilities."

For example, assume Harry was hired on June 1, 2001. As of April 2, 2004, he has two years of continuous service and is therefore eligible for 100% of his compensation for four weeks. Harry becomes disabled on April 3, 2004, and returns to work on April 23, 2004. From January 1, 2004, until April 3, 2004, because of illnesses Harry has been absent from work for a total of 5 days, or one week. Based on Harry's date of hire and his two years of continuous service, for the disability beginning April 3, 2004 he will receive 100% of his compensation for three weeks.

If you need more information about the Salary Continuation portion and your STD benefits, contact the HRSC at 1-888-THE-HRSC (1-888-843-4772).

The Accident and Sickness Portion

If you are still disabled as defined by the STD Plan, the Accident and Sickness portion pays two-thirds of your compensation when your salary continuation benefits end, for up to a maximum of 26 weeks of combined short-term disability payments (from the Salary Continuation portion and the Accident and Sickness portion).

How the Salary Continuation and Accident and Sickness Portions Work Together

If your continuous service is at least...	You receive payments from The Salary Continuation Portion for...	+	The Accident and Sickness Portion for...	=	For a Combined Maximum of...
3 months	2 weeks	+	24 weeks	=	26 weeks
2 years	4 weeks	+	22 weeks	=	26 weeks
4 years	6 weeks	+	20 weeks	=	26 weeks
10 years	18 weeks	+	8 weeks	=	26 weeks
14 years	26 weeks	+	0 weeks	=	26 weeks

Statutory Benefits

If you work in an area where state or local law prescribes that certain STD benefits be paid, those statutory benefits will be coordinated with any benefits you receive under the corporation's STD Plan, which replaces the statutory benefits. In most cases, your benefits under the corporation's STD Plan will be equal to or greater than the statutory benefits.

Receiving Benefits

If you are absent from work due to an illness lasting fewer than six days, you automatically receive STD benefits; you do not need to file a claim.

If you will be absent due to an illness lasting for more than five consecutive working days, or due to an accident or hospitalization lasting a day or more, and you are under a physician's care, you need to follow these steps to ensure that you continue to receive STD benefits:

- Notify your supervisor immediately.
- Contact Liberty Mutual at 1-800-853-7109.

The case manager assigned to you after you call will immediately contact your doctor to verify your disability status, and may contact your doctor periodically thereafter to check on your status. Benefit payments are issued weekly or semi-monthly, depending on how you normally are paid.

If you are not satisfied with the outcome of a claim you have submitted for benefits, you can ask that the claim be reviewed. See "Claims Review Process" in *Rules and Regulations* for information.

How Long Benefits Continue

Your STD benefits end on the earliest of the following dates:

- The date you recover (that is, the date you no longer meet the STD Plan's definition of disability, and your approved disability ends)
- The date you return to work (or if you are on maternity leave, the date you begin to use your vacation time or begin an unpaid FMLA leave)
- The date you do not provide proof of your disability or other information when requested by the corporation
- The date you stop receiving reasonable and appropriate medical treatment for your disability, as determined by the corporation
- The date the 26-week benefit period ends and LTD benefits may begin (different provisions apply in California)
- The day you die

Holidays and Vacation While on Disability

Although you get paid for holidays while you are receiving disability benefits, holidays that occur during your disability do not extend your disability leave beyond 26 weeks. Also, the holiday pay you receive is at the same percentage as the STD benefits you are receiving, so it will be only two-thirds of your pay if you are receiving benefits under the Accident and Sickness portion.

You cannot receive vacation pay while you are receiving disability benefits. If you are on maternity leave, you must take all your vacation time, except for one week, after your disability benefits end and before taking an unpaid leave or returning to work.

Pregnancy and Disability Coverage

If you are pregnant, some or all of your absence to have your baby will be covered under the STD Plan, because the end of your pregnancy (and your post-partum condition) is considered to be a disability.

If you are approved for a disability leave because of your pregnancy, you may receive a combination of Salary Continuation and/or Accident and Sickness benefits, depending on how long your leave lasts and your service with The McGraw-Hill Companies.

Generally, you may begin your maternity leave two weeks before your due date. (This may vary in some states.) To begin your leave, you will need to contact Liberty Mutual at 1-800-853-7109 and provide the information and documentation requested.

After your delivery, your maternity leave is still considered disability leave, but the length of the leave that is covered under the STD Plan depends on how your baby was delivered:

- If your baby is delivered by a normal vaginal delivery, you will be eligible for six weeks of disability leave.
- If your baby is delivered by cesarean section, you will be eligible for eight weeks of disability leave.

The actual amount of the benefit—that is, the pay you will receive while on maternity leave—is determined by your service. See "The Accident and Sickness Portion" for more information.

When any approved disability leave ends, you may apply for an unpaid leave of absence under the Family and Medical Leave Act (FMLA). See the information about FMLA leaves in the *Human Resources Guide*.

What's Not Covered

The STD Plan does not cover certain disabilities. These include

- disabilities that are related to your job,
- disabilities that are the result of war or international armed conflict,
- disabilities that are the result of an intentionally self-inflicted injury, while sane or insane,
- disabilities incurred during the commission of a felony or while engaging in an illegal operation, and
- disabilities that are the result of cosmetic surgery.

Recurring Disabilities

If you return to work and become disabled again because of the same or a related condition within two weeks after your approved STD leave ends...

- your recurring disability is considered one period of disability. Your STD benefits resume on the day after the recurrence, taking into account STD benefits already received. The benefit during your recurrence is based on your continuous service on the day before your disability began.

If you return to work and become disabled again because of the same or a related condition more than two weeks after your approved STD leave ends, or if the new disability is unrelated to the original one...

- your disability is considered a new period of disability. You again will receive STD benefits for up to a maximum of 26 weeks. Your Salary Continuation portion benefits, however, will be limited to no more than the number of weeks to which you are entitled because of your continuous service within a 12-month period beginning and ending with the anniversary of your date of employment (also known as your continuous service date).

If You Have More Than One Disability

Julie began working with the corporation on March 1, 2002. As of March 1, 2004, she has two years of continuous service and is therefore eligible for Salary Continuation portion benefits of 100% of pay for up to four weeks.

In March 2004, she is out sick for three weeks, so she has one week remaining of the four weeks she is eligible for.

A week after returning to work, Julie has a relapse and misses three more weeks of work. During this time, she receives her remaining week of salary continuation benefits (100% pay) and two weeks of accident and sickness benefits (two-thirds pay). Since Julie's relapse occurred within two weeks after her earlier STD leave ended, her disability is considered one period of disability, and her STD benefits picked up where they left off.

When Coverage Ends

Your short-term disability coverage ends on the earliest of the following dates:

- The day you retire or otherwise end your employment, whether voluntarily or involuntarily (If you are disabled before you retire or end your employment, STD benefit payments continue for up to the 26-week maximum.)
- The day you take a leave of absence, other than a disability leave (If you return to work, coverage automatically begins again.)

- The day you no longer meet the eligibility requirements for coverage
- The day the corporation discontinues the STD Plan
- The day you die

Long-Term Disability Coverage

When you are totally disabled as defined by the LTD Plan and unable to work for more than 26 weeks, the corporation's LTD Plan provides income continuation. The LTD Plan offers two levels of coverage:

- Basic coverage, which is provided at no cost to you, and
- Supplemental coverage, which you may purchase for additional disability protection.

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How the LTD Plan Works

Disabled Before October 1, 2003

The corporation's LTD plan changed effective October 1, 2003. If your disability began before October 1, 2003, the amount of your LTD benefit is based on the formula that applied at the time your disability began.

The LTD Plan pays a benefit if you are totally disabled as defined by the LTD Plan and unable to work for more than 26 weeks. The LTD Plan offers two levels of coverage:

- Basic coverage, which is provided at no cost to you, and
- Supplemental coverage, which you may purchase for additional disability protection.

For both basic and supplemental LTD coverage, your eligible compensation is limited to a maximum of $360,000 per year. The plan does not pay benefits on compensation that exceeds that $360,000 limit.

If you are eligible to receive LTD benefits, the benefits are payable provided that you remain disabled as defined by the LTD plan. Your LTD benefits may end, even if you still meet the definition of disability, as described in "How Long Benefits Continue" and "When Benefits End."

Basic Coverage

Basic LTD coverage provides you with 50% of your eligible compensation, up to a maximum monthly benefit of $10,000. If eligible, you are automatically enrolled for this coverage; you do not need to fill out any forms. The corporation pays the full cost of basic coverage.

Any benefits you receive under the basic coverage are subject to federal income tax.

Supplemental Coverage

If your compensation increases or decreases...

both your LTD coverage and your cost of coverage are adjusted accordingly.

Supplemental LTD coverage provides you with a total of 66⅔% (including your basic coverage benefit) of your eligible compensation, up to a combined monthly benefit (from both basic and supplemental coverage) of $20,000.

Because you pay for supplemental LTD coverage through payroll deductions on an after-tax basis, your supplemental LTD benefit, if you receive one, is generally not subject to federal income tax.

For example, if your compensation is $72,000 per year, or $6,000 per month, your LTD benefit would be $4,000 per month (66⅔% of $6,000). Of the total $4,000 benefit, $3,000 is from the basic LTD benefit (50% of $6,000) and $1,000 is from the supplemental benefit. You will pay federal income tax on $3,000 per month, but the remaining $1,000 usually will not be subject to federal tax. Some or all of your LTD benefit may be subject to state or local taxes. Be sure to consult your tax adviser for more information.

If Your Compensation Exceeds $360,000

Because of the $20,000 maximum monthly LTD benefit, the additional benefit that supplemental LTD coverage provides becomes a smaller percentage of your total compensation if your annual compensation is greater than the $360,000 limit on eligible compensation (66⅔% of $360,000 = $240,000 a year, or $20,000 a month). To offset this, the cost of supplemental coverage is based on eligible compensation under the LTD plan, which is limited to $360,000.

Evidence of Insurability to Enroll

Depending on when you enroll for supplemental coverage, you may have to provide evidence of insurability.

- If you enroll within 31 days of becoming eligible, you can enroll for supplemental coverage without providing medical evidence of insurability.

- If you enroll more than 31 days after becoming eligible, you must provide evidence of insurability, which is subject to insurance company approval before you will receive coverage. Providing evidence of insurability may include completing a medical questionnaire and/or having a physical evaluation. The corporation pays the cost of obtaining this evidence, including the cost of the physical examination.

Canceling Coverage

You may stop your supplemental coverage at any time by accessing Employee Self Service. Employee Self-Service is accessible only from The McGraw-Hill Companies Intranet. You can reach Employee Self-Service through a link on the Intranet homepage.

If you cancel coverage, your supplemental coverage ends on the last day of the month following cancellation. After you cancel supplemental coverage, you will still be covered by the basic LTD coverage.

When Coverage Begins and Ends

Your basic LTD coverage begins on the first day of the month after you are eligible for coverage.

For supplemental LTD, coverage for newly eligible employees (such as new hires) who apply for supplemental coverage within 31 days of becoming eligible is effective on the first day of the month after you are eligible. If you do not apply for LTD coverage within 31 days of becoming eligible, your supplemental coverage begins on the date the insurance company approves your application.

If you are absent due to illness or injury on the date your coverage is scheduled to begin, your coverage begins on the day you return to work.

Your LTD coverage ends on the earliest of the following dates:

- The day you retire or otherwise end your employment, whether voluntarily or involuntarily (If you are disabled before you retire or end your employment, your benefit payments may continue. See "How Long Benefits Continue" for more information.)
- The day you no longer meet the eligibility requirements for coverage
- For supplemental LTD coverage, the day you stop making the necessary contributions toward the cost of coverage
- The day the corporation discontinues the LTD Plan
- The day you die

Receiving Benefits

If you remain totally disabled as defined by the LTD Plan after receiving 26 weeks of STD benefits, you can expect to receive a benefit payment from the LTD Plan about 30 days after your STD benefits end, as long as

- you apply for Social Security disability benefits before your STD benefits end,
- you remain under the continuous care of a doctor, and
- you meet all requests for additional information and medical exams.

You may be required to undergo a medical examination by a doctor chosen by the corporation in order to receive or continue to receive LTD benefits.

If you are not satisfied with the outcome of a claim you have submitted for benefits, you can ask that the claim be reviewed. See "Claims Review Process" in *Rules and Regulations* for information.

Providing Proof of Disability

How Long Benefits Continue

Except as provided under "Benefits While Partially Disabled," to continue receiving LTD benefits you must remain totally disabled as defined by the LTD Plan. The requirements to be considered totally disabled change after you have been receiving LTD benefits for 24 months. The LTD Plan defines you as totally disabled if the following conditions apply:

Totally Disabled

For purposes of the LTD Plan, you are considered totally disabled if you are under the care of a physician and you meet the following requirements:

- During the 26-week period before long-term disability benefits begin and the next 24 months of your disability, you are unable to perform the material and substantial duties of your own occupation (as it is performed in the national economy) before your disability began, due to an injury or sickness.
- After you have received long-term disability benefits for 24 months, you are unable to perform, with reasonable continuity, the material and substantial duties of any occupation for which you are, or reasonably could become, qualified based on your training, education, experience, age or physical and mental capacity, due to an injury or sickness.

For the STD Plan, see the definition of "Disabled."

How long benefits are paid also depends on your age when your disability begins.

If You Become Disabled...	You Can Receive LTD Benefits...*
Before age 60	To age 65
Age 60 or older	For up to 5 years

**Benefits continue only as long as you remain totally disabled as defined by the LTD Plan.*

Credit for Retirement Plan

While you are out on a long-term disability leave, you continue to receive pension plan accruals and profit sharing plan contributions based on your pay when you became disabled. However, you may not make contributions to your 401(k) savings plan account. For more details on your corporation-sponsored retirement plans, see *Retirement Benefits*.

Benefits While Partially Disabled

If you are partially disabled, you are entitled to receive 75% of your eligible compensation (up to a maximum of $30,000 per month) after reduction for the compensation you are receiving while partially disabled. Partially disability benefits are subject to the benefit reductions listed under "Benefit Reductions."

You will be considered partially disabled if you earn between 20% and 80% of your eligible compensation before you became disabled and either:

- you are able to perform one or more, but not all, of the substantial duties of your own occupation or another occupation (that you could reasonably become qualified for) on a full- or part-time basis, or
- you are able to perform all of the substantial duties of your own occupation or another occupation (that you could reasonably become qualified for) on a part-time basis.

When Benefits End

Your payments under the LTD Plan continue, subject to the time limits explained under "How Long Benefits Continue," until the earliest of the following dates:

- The date you recover and are no longer totally disabled according to plan provisions, except as provided for in "Benefits While Partially Disabled."
- The date you fail to provide proof of your continuing disability or fail to take a medical exam as requested by the claims administrator or insurance company
- The date you are no longer under the continuous care of a doctor
- The date on which you are able to work in your own occupation (or another occupation that you could reasonably become qualified for)
- If you are partially disabled, the date on which you earn more than 80% of your eligible compensation before you became disabled
- The day you die

Retiring

If you become disabled before the normal retirement age of 65, you may begin receiving pension benefits at any time if

- you are age 55 or older, and
- you have 10 or more years of continuous service.

If you begin receiving your pension early, your LTD benefit is reduced by the amount of the pension benefit you receive, and your pension benefit is based on your service up to the date you begin receiving pension benefits. See *Pension Plan* for more information about your pension benefits.

What's Not Covered

The LTD Plan does not cover certain disabilities. These include:

- disabilities that are not being treated by a physician,
- disabilities that are the result of an intentionally self-inflicted injury, while sane or insane,
- disabilities that result from participation in the commission of a felony,
- disabilities that are the result of war, declared or undeclared,
- disabilities that result from active participation in a riot,
- disabilities that result from cosmetic surgery, unless such surgery results from trauma, infection, or other diseases and is in connection with an injury or sickness incurred while a participant, and
- disabilities that are due to a pre-existing condition, as described below.

Pre-Existing Conditions

If you receive treatment for a condition during the three-month period immediately before your coverage begins or is increased (a pre-existing condition), you will not receive LTD benefits relating to the new coverage for that condition until:

- you do not receive any additional treatment for that condition for at least three consecutive months after your coverage begins, or
- you have been covered by the LTD Plan for at least 12 months.

Recurring Disabilities

If you return to active, full- or part-time work after receiving benefits from the LTD Plan and then are totally disabled again within six months due to the same condition, your LTD Plan payments resume. Your monthly LTD payment will be the same as the amount you were receiving before your temporary return to work.

If you return to active, full- or part-time work after receiving benefits from the LTD Plan and then are totally disabled again more than six months later due to the same condition, the new disability is considered a separate illness. In this case, you are covered first by the STD Plan and then need to apply for LTD benefits.

If you return to active, full- or part-time work after receiving benefits from the LTD Plan, and you are then totally disabled by an unrelated illness or injury, the new disability is considered a separate illness. In this case, you are covered first by the STD Plan and then need to apply for LTD benefits.

Benefit Reductions

The LTD Plan will assume that you are receiving any Social Security benefits for which you or your dependents may be eligible because of your disability. The benefits you are eligible to receive from the LTD Plan are reduced by any payments you receive or are expected to receive from the following sources:

- Primary and family Social Security (If a cost-of-living increase in Social Security benefits takes effect while you are receiving LTD payments, your basic benefit is not reduced by the amount of the increase.)
- Workers' Compensation
- Other federal, state, or employer group insurance plans
- Mandatory "no-fault auto insurance"
- Unemployment benefits
- Benefits paid under any law similar to the above
- Corporation pension benefits. (Keep in mind that if you are eligible and decide to receive pension benefits from the corporation, you stop accruing additional pension benefits. See *Pension Plan* for details.)

Delayed Benefits

If Social Security Disability Income payments are delayed, the LTD Plan temporarily covers the difference. Once benefits from the other source begin, you will receive a payment—retroactive of what you originally were entitled to receive—from that source. When this happens, you will be required to repay the LTD Plan the additional amount that it paid to you. For instance, if the LTD Plan pays you an additional $500 benefit to cover a payment you did not receive from Social Security, once you receive that benefit from Social Security, you must repay the $500 to the LTD Plan.

Your Long Term Disability Benefit

Joe works for the corporation and is making $60,000 a year ($5,000 a month) when he becomes disabled. According to the corporation's plan, Joe is entitled to receive a total of $1,500 a month (30% of compensation) from all disability income sources. He receives $600 a month from Social Security. Here's how Joe's LTD payment from the corporation is calculated:

Total monthly basic LTD benefit (30% of compensation)	$1,500
Monthly primary Social Security benefit	−$600
Joe's monthly basic LTD payment from the corporation	= $900

In total, Joe will receive $1,500 a month: $600 from Social Security and $900 from the LTD Plan. The basic LTD benefit is taxable.

If Joe had purchased supplemental coverage from the corporation, he would have received an even greater disability benefit, as follows:

Total monthly basic LTD benefit (30% of compensation)	$1,500
Total monthly supplemental LTD benefit (16⅔% of compensation)	+ $833
Monthly primary Social Security benefit	−$600
Joe's monthly total LTD payment from the corporation	= $1,733

Note: Example assumes Joe does not receive family Social Security benefits.

Taking a Leave

Your basic and supplemental LTD coverages are suspended while you are on an unpaid leave.

Other Disability Coverage

In addition to the coverage under the corporation's Short-Term Disability (STD) Plan and the Long-Term Disability (LTD) Plan, most employees have coverage from Workers' Compensation and Social Security. You may be eligible for Workers' Compensation insurance benefits if you have a job-related disability, and for Social Security disability benefits whether or not your disability is job related.

If you are eligible for benefits under either of these programs, they will reduce or offset benefits you receive under the corporation's disability plans.

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Workers' Compensation

Under Workers' Compensation insurance, you receive benefits when you are unable to work due to a job-related illness or injury. As an active employee of the corporation working in the United States, you are eligible for Workers' Compensation insurance coverage and are automatically covered by state law from your first day of work. There is no cost to you for this insurance and you do not need to fill out any forms to be covered.

Receiving Benefits

You should file a claim for Workers' Compensation benefits as soon as you are out of work due to a job-related illness or injury. For help filing a claim, call your manager or human resources representative.

Amount of Your Benefit

Workers' Compensation benefits vary from state to state, and the duration of disability payments is usually determined by the nature of the illness or injury.

Eligibility for Other Benefits

If you are eligible to receive Workers' Compensation benefits, you also may be eligible for benefits from the corporation's LTD Plan. You should be aware that any payments you receive from the LTD Plan are reduced by the amount of the Workers' Compensation payments you receive.

If You Leave the Corporation

If you leave the corporation or retire, you are no longer covered by Workers' Compensation insurance. However, benefit payments that began before you leave the corporation will continue to be paid, up to the maximum amount of benefits you are entitled to receive under state law.

Social Security Disability Benefits

If you become disabled and are unable to work, you may qualify for Social Security disability benefits if

- your disability has lasted at least five months, and
- your disability is expected to last at least 12 months.

Social Security provides these two types of benefits:

- Primary benefits, which are paid to you, and
- Family benefits, which are paid to you for your family members.

For More Information

If you need more information about Social Security disability benefits, contact your local Social Security Administration office.

Receiving Benefits

Social Security payments generally begin when you have been disabled for six months, provided you have filed your claim for benefits before then. Because it could take considerable time to process your claim, you should file for Social Security benefits before the fifth month of your disability.

To begin the process, call your local Social Security Administration office. You will receive a medical report form to be completed by your doctor or by the hospital or clinic where you were treated. Claims must be submitted to the Social Security Administration at the address on the form.

Amount of Your Benefit

The amount of your Social Security benefit depends on your employment history.

- If you are disabled before age 65, the amount of your monthly benefit is the same as the retirement benefit you would receive from Social Security at age 65, and reflects your wage history while you were working.
- If you are disabled after age 65, you will receive your Social Security retirement benefit. For specific information about the amount of your benefit, contact your local Social Security Administration office.

Eligibility for Other Benefits

If you are eligible for benefits from Social Security and from the corporation's LTD Plan, your LTD benefits are reduced by the amount of your Social Security payments. For more information, see "How the LTD Plan Works."

If Your Claim Is Denied

If your claim for Social Security disability benefits is denied, you may still be eligible for benefits from the corporation's LTD Plan. (See "How the LTD Plan Works" for more information). However, if you are receiving LTD benefits, the corporation may periodically require you to file another claim for Social Security benefits.

Life and Accident Insurance

The McGraw-Hill Companies life and accident insurance programs provide you and your family with financial assistance in case of death or severe injury. You have a number of options that can be customized to meet your family's needs. You should consider several factors—such as your marital status, the number of children you have and their ages, your spouse's employment status and other financial assets available to your family in the event of your death—to help you determine the type and amount of insurance coverage you need.

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Life insurance coverage offers you and your family financial protection if a covered family member dies. The corporation provides eligible employees with basic life insurance coverage automatically and at no cost to you, through the Group Term Life Insurance Plan. You also may purchase supplementary coverage for yourself. In addition, you may purchase life insurance coverage for your spouse and dependent children through the corporation's Group Voluntary Spousal Life Insurance Plan and Group Voluntary Dependent Life Insurance Plan. For more information, see the *Life Insurance Coverage* section.

Accidental death and dismemberment (AD&D) insurance coverage can pay benefits if you or a covered family member dies or is seriously injured as the result of a covered accident. You may purchase coverage for yourself, your spouse, and your children, through the corporation's Group Voluntary Accidental Death and Dismemberment Plan (providing employee coverage) and Group Voluntary Dependent Accidental Death and Dismemberment Plan (providing coverage for your spouse and dependent children). The AD&D plan benefits are limited, depending on the percentage of loss. For more information, see "How Benefits Are Paid" in the *AD&D Insurance Coverage* section.

Corporation executives at or above salary level 23 (or equivalent) are also covered under a special 24-hour personal AD&D insurance program. For more information, see "Executive 24-Hour AD&D Insurance" in the *AD&D Insurance Coverage* section.

The corporation's Group Travel Accident Insurance Plan provides coverage automatically and at no cost to all active employees at or below salary level 22. Travel accident insurance can pay benefits if you, your spouse, or a dependent child dies or suffers certain injuries as the result of an accident that occurs while you are traveling on business for the corporation. For more information, see *Travel Accident Insurance*.

Terms to Know

Annual Compensation

For purposes of the corporation's life and accident insurance plans, your annual compensation consists of your current pay plus short-term incentive compensation, overtime, and shift differential pay for the prior year. If you are paid on a commission or targeted income basis, your annual compensation includes your current annual rate of compensation/draw and planned additional compensation, plus overtime pay for the prior year. If you are a newly hired employee working on a commission-only basis, your annual compensation for these benefits is the estimated annual compensation as determined by your manager.

Life Insurance Coverage

If you are an eligible employee, the corporation provides you with basic life insurance coverage automatically at no cost to you, through the Group Term Life Insurance Plan. The basic coverage is equal to your total annual compensation up to $100,000.

This plan also allows eligible employees to purchase supplementary coverage for themselves. In addition, eligible employees may purchase life insurance coverage:

- for their spouses through the corporation's Group Voluntary Spousal Life Insurance Plan, and
- for their dependent children through the corporation's Group Voluntary Dependent Life Insurance Plan.

Broadcasting Group Participants Before January 1, 2004

Prior to January 1, 2004 employees of the McGraw-Hill Broadcasting Company were covered under a different life insurance plan. If you were in that plan on December 31, 2003, the coverage at the level that plan provided for you as of December 31, 2003 continues. If you have coverage at the old Broadcasting plan level and you switch to coverage under the current plan, you will not be able to switch back to the old Broadcasting plan benefit.

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Your Life Insurance Options

Coverage Is Reduced at Age 65

At age 65, basic and supplementary life insurance coverages are automatically reduced by 35%, as described under "Cost of Employee Coverage" in "Paying for Coverage." If you continue to work after age 65, you may convert the reduced portion to an individual policy. See "Converting Coverage" for details.

As an eligible employee, you automatically receive basic life insurance coverage from the corporation.

In addition to your basic life insurance, the corporation offers supplementary life insurance coverage. The supplementary coverage lets you enroll for:

- additional life insurance coverage for yourself,
- spousal life insurance for your spouse, and
- children's life insurance for your eligible dependent children.

Basic Life Insurance

The corporation provides you with basic life insurance—equal to your total annual compensation up to $100,000—at no cost to you. If your annual compensation is more than $50,000, you may limit your coverage to $50,000 to avoid imputed income and the tax that would be due on that income.

If you wish to elect the $50,000 option, you have 31 days from the date you first meet the eligibility requirements to notify the Human Resources Service Center (HRSC) toll-free at 1-888-THE-HRSC (1-888-843-4772). Otherwise, you automatically receive basic life insurance in the amount of one times annual compensation, up to $100,000. You may also elect the $50,000 option during open enrollment.

If you elect the $50,000 option, you may later change your mind and remove the limit at any time by calling the HRSC.

Taxes on Imputed Income

If the basic life insurance coverage provided at no cost to you by the corporation is more than $50,000, the value of any coverage amount above $50,000 is considered to be "imputed income" and is subject to taxes. The amount of imputed income is reported on your W-2 form.

The Internal Revenue Service determines the value of life insurance above $50,000 using a life insurance table that reflects your age. The chart below shows the monthly value of each $1,000 of coverage greater than $50,000.

If you are...	The monthly value for each $1,000 of coverage over $50,000 is...
Under age 25	$0.05
Age 25 to 29	$0.06
Age 30 to 34	$0.08
Age 35 to 39	$0.09
Age 40 to 44	$0.10
Age 45 to 49	$0.15
Age 50 to 54	$0.23
Age 55 to 59	$0.43
Age 60 to 64	$0.66
Age 65 to 69	$1.27
Age 70 and above	$2.06

How much additional tax can I expect to owe if I have basic life insurance coverage over $50,000?

The amount of your additional tax liability depends on your personal situation, but here's an example to help you get an idea of the tax you might owe.

Suppose you are 50 years old and have basic life insurance coverage of $70,000. This means you must pay taxes on the value of $20,000 of coverage. Based on your age, the monthly value for each $1,000 over $50,000 is $0.23. Therefore, your additional taxable income—or imputed income—is $4.60 per month (20 times $0.23), or $55.20 per year. Note that $55.20 is *not* the tax you would pay—it is the income subject to FICA and income taxes. If your income tax rate were 30%, the additional annual tax you would pay for this coverage would be $16.56. Contact your tax advisor and/or your insurance agent if you have questions about imputed income.

Supplementary Life Insurance

Although basic life insurance coverage is automatic, supplementary life insurance coverage is optional.

Another difference between basic life insurance and supplementary coverage is that you may need to provide evidence of insurability before any supplementary coverage, for you or your family members, can begin. See the discussion of evidence of insurability in "How to Enroll" for more information.

Additional Coverage for Employees

As an eligible employee, you may purchase supplementary life insurance coverage for yourself in the amount of one, two, three, four, or five times your annual compensation (rounded to the next $500), up to a maximum coverage amount of $2 million.

Changes in Annual Compensation

If your annual compensation increases during the year, your basic and supplementary coverage also increases, up to the maximum amount allowed. However, if you choose to limit your basic life insurance coverage to $50,000, your basic life insurance coverage does not increase when your compensation increases.

If your annual compensation decreases, your insurance is not reduced unless you request, in writing, a reduction of your coverage. For more information about reducing your coverage, contact the Human Resources Service Center (HRSC) toll-free at 1-888-THE-HRSC (1-888-843-4772).

Coverage for Your Family Members

If you are eligible, you may purchase life insurance coverage for your spouse through the corporation's Group Voluntary Spousal Life Insurance Plan and for your dependent children through the corporation's Group Voluntary Dependent Life Insurance Plan.

Your Spouse

You may purchase life insurance coverage for your spouse in amounts from $10,000 to $100,000, in $10,000 multiples. You may not purchase life insurance coverage for a domestic partner or any adult family member other than your spouse. See the discussion of domestic partners and non-spouse adults in "Eligibility and Enrolling" for more information.

Your Dependent Children

You may purchase life insurance coverage for your eligible dependent children at coverage levels of either $5,000 or $10,000. The amount you select applies to all your eligible children.

For children from ages 14 days to six months, the maximum benefit payable is $500, regardless of the amount of coverage you choose. The full coverage amount you select goes into effect when your child reaches six months of age.

Eligibility and Enrolling

Ineligible Individuals

Even if you meet the eligibility requirements, you cannot participate if you fall into one or more of the groups listed under "Individuals Not Eligible" in *Rules and Regulations*.

You are eligible to enroll for life insurance coverage if:

- you are employed by a corporation business unit that participates in the applicable plan,
- you are an active full-time or an active part-time employee,
- you are regularly scheduled to work at least 20 hours per week, and
- you are employed in the United States, or you are a U.S. employee temporarily working abroad.

If you meet these eligibility requirements when first hired by the corporation, you are eligible as of your hire date. If you do not meet these requirements when first hired, you are not eligible until your employment status changes to meet the eligibility requirements.

Eligibility for Family Members

If you are eligible, you may enroll your spouse for life insurance coverage as long as your spouse is:

- your legal spouse according to the laws where you live and
- under age 70.

Domestic Partners and Non-Spouse Adults Not Eligible

The corporation's life and accident insurance plans are provided under insurance contracts that must be approved by and filed with state insurance commissions. Coverage is not available for domestic partners or for any other adult family members—except for your spouse—because these contracts govern coverage eligibility.

Dependent Children

Your children can be enrolled for life insurance coverage, provided that they are at least 14 days old and satisfy the requirements below that define who is considered your child and whether those children are considered dependents.

If you are an eligible employee, you can enroll your eligible dependent children. Eligible children include children:

- by birth,
- by adoption (effective as of the date the child is placed for adoption),
- stepchildren, and
- children for whom you are legally responsible.

Eligible dependent children include your children (as defined above) who:

- are under age 23,
- are not married,
- are not employed on a full-time basis,
- are dependent on you for financial support, and
- either:
  - live with you, or
  - are away at school.

Disabled Dependent Children

If your child becomes totally and permanently disabled before age 23, that child is eligible for coverage as your dependent as long as:

- the child is not married,
- the child is living with you,
- the child remains disabled, and
- the child is dependent on you for financial support.

To cover disabled dependent children, you must verify in writing that the disability occurred before age 23. You have 31 days from the child's 23rd birthday to provide this verification.

During the next two years, from time to time, you may be required to provide proof that the child's disability is continuing and that the child remains dependent on you. After that, you will be required to provide continuing information only once a year.

How to Enroll

There is no need to enroll for basic life insurance coverage for yourself; participation begins automatically as of the first day you are an eligible employee. However, you must name a beneficiary so that your life insurance benefits can be distributed in the event of your death. For more information, see "Naming a Beneficiary."

You can name your beneficiary on Employee Self-Service or by contacting the Human Resources Service Center (HRSC) toll-free at 1-888-THE-HRSC (1-888-843-4772).

Employee Self-Service is accessible only from The McGraw-Hill Companies Intranet. You can reach Employee Self-Service through a link on the Intranet homepage.

Supplementary Life

You may enroll for supplementary life insurance for yourself as of the first day you are an eligible employee, or you may enroll at any time after that. If you enroll for coverage that is less than $250,000 within 31 days of becoming eligible, you do not have to provide evidence of insurability to enroll. In all other cases—such as enrolling later or enrolling for coverage of $250,000 or more—you must provide evidence of insurability before your supplementary life insurance coverage can begin. You can begin the application process by using Employee Self-Service.

Spousal and Children's Life

You may enroll your spouse and/or children for life insurance at any time after you are eligible. To enroll for coverage, you must apply to the insurance company and your application must be approved by the insurance company before coverage can begin. In most cases, you must submit evidence of insurability before the coverage will be approved, as explained in "Evidence of Insurability."

The insurance company reviews each application and will contact you regarding your coverage. You can begin the application process by using Employee Self-Service.

Evidence of Insurability

In some cases, you must provide evidence of insurability—that is, proof of good health—before life insurance coverage can begin. (Note that because your basic life insurance coverage is automatic, no evidence of insurability is required for that coverage.)

- **Supplementary Life Insurance for Yourself**—You can enroll for supplementary life insurance without providing evidence of insurability if:
  - you enroll within 31 days of becoming eligible, and
  - you enroll for coverage of less than $250,000.
- **Spousal Life Insurance**—Evidence of insurability is always required for spousal life insurance, regardless of when you enroll or how much coverage you elect.
- **Children's Life Insurance**—You can enroll your children for life insurance coverage without providing evidence of insurability if:
  - you enroll your child within 31 days of the date your child becomes eligible, or
  - you enroll your child during the annual enrollment period.

If evidence of insurability is required, the insurance company will arrange a time and place for the person applying for insurance to complete a questionnaire and take a physical exam. (If you elect children's life insurance, you need to complete a questionnaire but your child does not need to have a physical exam.) The corporation pays the full cost of this exam and any related lab tests.

Naming a Beneficiary

As part of enrolling, you should name a beneficiary for your basic and supplementary life insurance coverage. Beneficiaries can be any person or organization you choose, except your employer.

Your spouse must name the beneficiary for spousal life insurance. If your spouse does not name another person, the employee is automatically the beneficiary.

You are automatically the beneficiary for children's life insurance unless you name another person.

The beneficiary on record can be changed at any time on Employee Self-Service. Employee Self-Service is accessible only from The McGraw-Hill Companies Intranet. You can reach Employee Self-Service through a link on the Intranet homepage.

Your beneficiary designation must be on file with the HRSC at the time of your death for your beneficiary to receive benefits.

If you die and you have not elected a beneficiary for your life insurance coverage, or if the beneficiary you named is not alive, the insurance company has the option either to pay benefits to your estate or to pay benefits to your first surviving relative(s), in the following order:

- Spouse
- Children
- Parents
- Siblings

Paying for Coverage

The corporation pays the full cost of your basic life insurance. Depending on your annual compensation, the basic life insurance coverage you receive may create imputed income for which you will have a tax liability. See the discussion of taxes on imputed income in "Basic Life Insurance" for more information.

You pay for supplementary, spousal, and children's life insurance through after-tax payroll deductions. Contributions for life insurance coverage begin after your coverage goes into effect.

Your Costs

You can find out the exact cost of the different coverage options available to you by accessing Employee Self-Service. Employee Self-Service is accessible only from The McGraw-Hill Companies Intranet. From the Intranet homepage, go to Top Sites and click the button that says "Employee Self-Service."

Cost of Employee Coverage

The cost for supplementary life insurance is based on your annual compensation, your age, and the amount of coverage you choose. Your contributions increase as your annual compensation increases and as you reach the next higher age bracket. Contribution increases become effective with the first pay period following the increase in your compensation or your birthday, whichever is causing the contribution change. If the premiums increase, contribution increases will take effect on the following January 1.

Basic and supplementary life insurance coverage is reduced by 35% when you reach age 65. If you continue to work past age 65, your coverage is reduced but your contributions for supplementary coverage remain unchanged. For example, suppose you are younger than 65 and pay $44.16 a month for $48,000 of coverage. At age 65, your coverage would be reduced by 35% to $31,200 but you would continue to pay $44.16 each month.

Cost of Family Coverage

Costs for spousal life insurance are based on your spouse's age and on the amount of coverage you choose. Contributions increase as your spouse reaches the next higher age bracket.

For children's life insurance, you pay a flat dollar amount based on the amount of coverage you choose. The contributions you pay provide life insurance coverage for all your eligible dependent children regardless of how many children you have.

Contributions When Not on Payroll

If you are eligible to continue participating in a corporation plan when you are not an active employee, you must make arrangements to pay any required contributions to the corporation directly. Before you go on inactive status, call the HRSC to discuss your options and make appropriate arrangements.

Depending on the reason why you are not active, your payment options may include:

- prepaying contributions, through an after-tax deduction from your final paycheck(s) before you become inactive,
- prepaying contributions on an after-tax basis with a direct payment to the corporation, or
- paying your contributions on an installment basis, after taxes, according to a schedule that would be worked out by the HRSC before you become inactive.

When Coverage Begins

Basic life insurance coverage begins as of the date you become eligible, so long as you are actively at work on that date. (Typically, this is your date of hire). If you are not actively at work on the day your basic coverage is supposed to begin, coverage begins when you return to active status.

If you enroll for supplementary life insurance coverage of less than $250,000 within 31 days of the date you become eligible...

- no evidence of insurability is required, and your supplementary life insurance coverage begins on the date you became eligible (so long as you are actively at work on that date). If you are not actively at work on the day your supplementary life insurance coverage is supposed to begin, coverage begins when you return to active status.

If evidence of insurability is required for your supplementary life insurance coverage...

- your coverage begins the day the insurance company approves your application, so long as you are actively at work on that date. Therefore, if you enroll for supplementary life insurance coverage of $250,000 or more or enroll more than 31 days after becoming eligible, basic life insurance coverage in the amount of one times your annual compensation, up to $100,000, begins on the day you become eligible and the supplementary coverage you chose begins after your evidence of insurability is accepted by the insurance company, so long as you are actively at work on that date.

For more information, see the discussion of evidence of insurability in "How to Enroll."

Your Family Members

If you enroll your spouse for life insurance, his or her coverage begins the day the insurance company approves his or her application for coverage.

For children's life insurance, the date coverage begins depends on whether evidence of insurability is required.

If no evidence of insurability is required, your child's coverage begins...

- on the day he or she becomes eligible, if you enroll within 31 days of his or her eligibility date.
- on the following January 1, if you enroll during the annual enrollment period.

If evidence of insurability is required...

- your child's coverage begins the day the insurance company approves his or her application for coverage.

How Benefits Are Paid

Life insurance benefits are paid in one lump sum to the beneficiary on record. For more information on identifying the beneficiary on record, see "Naming a Beneficiary."

Terminal Illness

If you become terminally ill, you may have as much as 50% of your supplementary life insurance—up to $50,000—paid to you before you die. This is known as a living needs benefit.

For you to receive a living needs benefit, a physician must certify that you are terminally ill and that you have a life expectancy of not more than six months. Any amounts paid through this feature reduce the benefit payable at your death.

There are tax implications to taking a living needs benefit. You should consult a tax advisor before taking an early payment since the tax treatment may be less favorable than a death benefit. Call the Human Resources Service Center (HRSC) toll-free at 1-888-THE-HRSC (1-888-843-4772) for more information about the living needs benefit.

Paying for Coverage

If you are terminally ill and receiving long-term disability benefits, see "Contributions When Not on Payroll" in "Paying for Coverage" for information on how you pay any required contributions to continue coverage.

Assigning Your Benefits

Plan provisions allow you to transfer ownership of your basic and supplementary life insurance benefits to another person or organization. However, there are considerations to take into account before making this decision, so you may want to consult your tax or legal advisor before doing so. For information, contact the HRSC.

Filing a Claim

To file a claim, notify the Human Resources Service Center (HRSC) toll-free at 1-888-THE-HRSC (1-888-843-4772). A representative will explain the benefits that are provided and what is needed to process the claim. If you or your spouse is to receive benefits from this plan, you must file a written claim with the insurance company. In the case of your death, your manager notifies the HRSC and the HRSC contacts the beneficiary (see "Naming a Beneficiary") on file.

Before death benefits can be paid, the insurance company must receive a certified copy of the death certificate and a written claim. Payment is usually made within 90 days after all the proper documentation has been received.

Claiming Death Benefits

To file a claim, notify the HRSC and file a written claim with the insurance company. Before death benefits can be paid, the insurance company must receive a certified copy of the death certificate and a written claim.

When Benefits Are Not Paid

If your spouse's or your child's death results from suicide during the first two years coverage is in effect, the death benefit is limited to a refund of contributions. This limit does not apply to employee coverage.

When Coverage Ends

For More Information

See "Post-Retirement Coverage" for a description of the Group Life Insurance Plan for Retirees.

See "Converting Coverage" for information on conversion and on continuing coverage through the portability feature.

If you are not eligible for retiree coverage under the Group Life Insurance Plan for Retirees or if you do not continue your coverage through the portability feature or convert your life insurance to an individual policy, your life insurance coverage ends on the earliest of the following dates:

- The last day of the month in which you retire or otherwise end your employment (whether voluntarily or involuntarily). If you are eligible for severance benefits under the Separation Pay Plan and you choose to receive those benefits in installments, some benefits can continue while you are receiving those installments. See "Continuing Benefits Coverage" in the section on the Separation Pay Plan in *Other Benefits*.
- The last day of the month in which you no longer meet the eligibility requirements for coverage
- The last day of the month in which you stop making the necessary contributions toward the cost of coverage
- The day the corporation discontinues the plan
- The day you die

Your Family Members

If you have enrolled for spousal and/or children's life insurance, the covered family members' coverage ends on the earliest of the following dates:

- The day your coverage as an employee ends (as previously explained)
- The last day of the month in which your family member no longer meets the eligibility requirements for coverage
- The day the corporation discontinues coverage for family members under the plan. (You may be able to convert coverage.)
- The last day of the month in which you stop making the necessary contributions toward the cost of dependent coverage
- The day the covered family member dies

When a spouse's or child's eligibility ends, access Employee Self-Service so you can stop paying the required contributions for their coverage.

Employee Self-Service is accessible only from The McGraw-Hill Companies Intranet. You can reach Employee Self-Service through a link on the Intranet homepage.

Canceling Coverage

You may discontinue supplementary, spousal, or children's life insurance at any time. You can begin this process by accessing Employee Self-Service. If you wish to reapply for supplementary life insurance at a future date, you will need to furnish evidence of insurability at your expense. If you wish to enroll your spouse or children again at a future date, you will need to submit a new application to the insurance company and provide the required evidence of insurability.

What Happens When...

In certain instances, you may be entitled to continue life insurance coverage, even if your employment with the corporation ends.

You Become Disabled

If you become totally disabled while you are an active employee and are approved for benefits from the corporation's Long-Term Disability (LTD) Plan, your basic life insurance coverage continues at no cost to you. However, you must continue your contributions for supplementary life insurance during your disability leave if you want to keep this coverage in effect. For information on paying contributions when you are totally disabled, see "Contributions When Not on Payroll" in "Paying for Coverage."

During your disability, your insurance will continue according to the following schedule.

How Coverage Continues If You Are Totally Disabled

If Your Disability Begins...	Your Basic and Supplementary Life Insurance Coverages...
Before age 60	are continued to age 65. At age 65, they are reduced to $4,000 and continued for life at no cost to you, provided you are eligible for retiree life insurance (see "Post-Retirement Coverage" for more information).
At or after age 60	are continued for five years and at age 65, reduced by 35%. At the end of the five-year period, these coverages are reduced to $4,000 and continued for life at no cost to you, provided you are eligible for retiree life insurance (see "Post-Retirement Coverage" for more information).

In all instances, if your basic or supplementary life insurance is reduced, you may convert the reduced portion to an individual policy. See "Converting Coverage" for more information.

You Take a Leave

If you take an approved leave of absence, life insurance coverage for you and your family members continues for the entire period of your leave, provided you continue to make the required contributions. For information on paying contributions when on leave, see "Contributions When Not on Payroll" in "Paying for Coverage."

You Retire

When you retire, if you are eligible, you are automatically enrolled in The McGraw-Hill Companies Group Life Insurance Plan for Retirees. Under this plan, the corporation continues $4,000 of your life insurance coverage at no cost to you. See "Post-Retirement Coverage" for more information.

If you are not eligible for the Group Life Insurance Plan for Retirees, or if you do not wish to continue your supplementary coverage through the portability feature or convert your basic and supplementary life insurance to individual policies, your coverage ends on the last day of the month in which you retire. See "Converting Coverage" for information on conversion and on continuing coverage through the portability feature.

Your Employment Ends

If you leave the corporation, the supplementary life insurance plan's portability feature allows you to continue your life insurance coverage without paying a fee to convert the policy and without providing evidence of insurability. The rates for continuing coverage will be better than rates for purchasing an individual policy or for converting your coverage to an individual policy. The portability feature is not available for basic life insurance, but you can convert basic life insurance coverage to an individual policy.

When you notify the corporation of your intention to leave, you automatically receive an application for continuing coverage.

If you wish to continue life insurance coverage for your spouse or children, you may apply to convert the coverage. See "Converting Coverage" for information on conversion.

You Die

If you die, your manager notifies the HRSC and the HRSC contacts the beneficiary (see "Naming a Beneficiary") on file.

If your spouse and children have dependent life insurance coverage and wish to continue that coverage, they may apply to convert the coverage. See "Converting Coverage" for information on conversion.

Converting Coverage

When your basic life insurance coverage ends, you may either let the coverage lapse or convert the coverage to an individual policy with the insurance company as long as you do so within 31 days.

If you retire and do not meet the eligibility requirements for retiree life insurance, you may convert all of your group life insurance to an individual policy. If you do so, you pay the regular individual policy insurance company rates for your age at the time you buy the insurance, but you do not have to provide evidence of insurability. The rates for converted coverage can be significantly more expensive than the rates for the group coverage available to active employees. Therefore, you should check other sources of insurance coverage several months before your retirement date. Once you retire, you must make your decision about conversion within 31 days of your retirement date.

Insurance Portability

For your supplementary life insurance coverage, you have an option in addition to conversion. You may convert the supplementary coverage to an individual policy, or you may use the plan's portability feature to continue your coverage at group rates somewhat higher than those available to active employees but lower than individual policy rates.

Continuing coverage through the portability feature is less expensive than if you were to convert your coverage to an individual policy or purchase life insurance on your own. You may apply for the portability option if your insurance is discontinued because you:

- terminate employment,
- change to a regularly scheduled work week of fewer than 20 hours a week, or
- retire.

If your life insurance is discontinued for one of the reasons above, you may apply for the portability option, provided you do so within 31 days of the date you terminate employment, change your hours, or retire. You are not required to submit evidence of insurability. There will be no lapse in your coverage.

Within three weeks after Prudential receives your enrollment form, you will be sent a billing statement. Your first billing statement serves as confirmation that you have been properly enrolled. All payments must be made promptly to maintain your life insurance. If you have questions about the portability feature, call Prudential's Life Services Division at 1-800-562-9874.

If you die during the 31 days before your insurance is continued through the portability feature or converted to an individual policy, your beneficiary receives a lump-sum payment of the amount you were entitled to continue or convert, even if you did not apply for continuation or conversion.

Conversion vs. Portability

When your corporation-provided coverage ends, you may be able to convert your coverage to an individual policy or you may be able to continue your coverage using the plan's portability feature.

- If you convert your coverage, you will pay individual policy premiums, which are significantly higher than the premiums for group coverage through the corporation.
- If you continue your coverage through the portability feature, you will receive a group rate. You'll pay more than you did as an active employee, but less than if you convert to an individual policy.

Reduced Coverage at Age 65

When you reach age 65, your employee basic and supplementary life insurance coverages are automatically reduced by 35%.

- If your basic life insurance is going to be reduced because you're turning 65 (see "Cost of Employee Coverage" in "Paying for Coverage") or retiring (see "Post-Retirement Coverage"), you may convert the portion you would otherwise lose through the reduction to an individual policy. You must convert the policy before you turn age 65 or within 31 days of retiring.
- If your supplementary life insurance is going to be reduced because you're turning 65, you may use the plan's portability feature to continue your coverage at group rates. These rates are higher than those available to active employees but lower than individual policy rates.

Life Insurance for Family Members

Life insurance for your spouse or dependent children can be converted to an individual policy with the insurance company without evidence of insurability. The premium is determined by insurance company rates. Your spouse must be under age 70 to be eligible to convert coverage. You must apply within 31 days after your spouse and/or children's group coverage ends.

Post-Retirement Coverage

When you retire, if you are eligible, you are automatically enrolled in The McGraw-Hill Companies Group Life Insurance Plan for Retirees. This plan automatically provides you with $4,000 of life insurance coverage at no cost to you. You don't need to enroll. If you die within 31 days of retiring, your beneficiary (see "Naming a Beneficiary") will receive the full amount of insurance—both basic and supplementary—you had immediately before you retired.

Contact the Human Resources Service Center (HRSC) toll-free at 1-888-THE-HRSC (1-888-843-4772) if you'd like more information about the Group Life Insurance Plan for Retirees.

Eligibility for Retiree Coverage

You are eligible for retiree life insurance if you meet one of the following requirements:

- You are age 55 or older with at least 10 years of continuous service and are eligible for a pension plan (ERP) benefit from the corporation.
- You are age 50 or older with at least 20 years of continuous service and are terminated through no fault of your own.

Retiree life insurance coverage is limited to $4,000. If you wish to have more than $4,000 of life insurance coverage or if you are not eligible for the Group Life Insurance Plan for Retirees, you can continue your life insurance coverage as explained in "Converting Coverage." If you wish to continue your coverage, you must do so within 31 days of retiring, so consider your options well in advance of your retirement.

When Retiree Coverage Begins and Ends

If you are eligible, retiree life insurance coverage begins automatically when you retire.

Your retiree life insurance coverage ends on the earlier of the following dates:

- The day the corporation discontinues the plan, or
- The day you die

AD&D Insurance Coverage

If you or a covered family member dies or is seriously injured as the result of a covered accident, Accidental Death and Dismemberment (AD&D) insurance coverage can pay benefits.

You may purchase coverage:

- for yourself through the corporation's Group Voluntary Accidental Death and Dismemberment Plan, and
- for your spouse and your children through the Group Voluntary Dependent Accidental Death and Dismemberment Plan.

The corporation also provides a special 24-hour personal accidental death and dismemberment (AD&D) insurance program for executives at salary level 23 (or the equivalent) or above. See "Executive 24-Hour AD&D Insurance" for more information.

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Your AD&D Options

Executive 24-Hour AD&D Program

Certain executives at salary level 23 and above are covered under a special 24-hour personal AD&D program. See "Executive 24-Hour AD&D Insurance."

If you are an eligible employee, you may purchase accidental death and dismemberment (AD&D) insurance for yourself through the corporation's Group Voluntary Accidental Death and Dismemberment Plan.

If you enroll for AD&D coverage for yourself, you may also purchase coverage for your spouse and/or dependent children through the Group Voluntary Dependent Accidental Death and Dismemberment Plan. However, you cannot purchase more coverage for your spouse than you have for yourself.

Your coverage options are as follows:

- **Employee AD&D Insurance**—Choose coverage equal to one to 10 times your annual compensation, rounded to the next higher $10,000, up to a maximum of $750,000.
- **Spousal AD&D Insurance**—Choose coverage from a minimum of $25,000 to a maximum of $300,000, in $25,000 increments.
- **Children's AD&D Insurance**—Choose coverage for all of your eligible dependent children equal to either $10,000 or $20,000 for each child.

The coverage you elect becomes the full benefit amount that is payable if the covered person dies in an accident—this is also known as the "death benefit." If the covered person suffers one of the accidental losses described under "Amount of Your Benefit," the plan pays a percentage of the death benefit.

Changes in Annual Compensation

If your annual compensation increases during the year, your employee AD&D coverage also increases, up to the maximum amount allowed.

If your annual compensation decreases, your insurance is not reduced unless you request, in writing, a reduction of your coverage. For more information about reducing your coverage, contact the Human Resources Service Center (HRSC) toll-free at 1-888-THE-HRSC (1-888-843-4772).

Eligibility and Enrolling

Ineligible Individuals

Even if you meet the eligibility requirements, you cannot participate if you fall into one or more of the groups listed under "Individuals Not Eligible" in *Rules and Regulations*.

You are eligible to enroll for accident insurance coverage if you are younger than age 70 and:

- you are employed by a corporation business unit that participates in the applicable plan,
- you are an active full-time or an active part-time employee,
- you are regularly scheduled to work at least 20 hours per week, and
- you are employed in the United States, or you are a U.S. employee temporarily working abroad.

If you meet these eligibility requirements when first hired by the corporation, you are eligible as of your hire date. If you do not meet these requirements when first hired, you are not eligible until your employment status changes to meet the eligibility requirements.

You may enroll for AD&D coverage as of the first day you are eligible or at any time after that.

Eligibility for Family Members

No Evidence of Insurability

You do not need to provide evidence of insurability to enroll for AD&D coverage.

If you are eligible, you may enroll your spouse and dependent children for AD&D insurance coverage as long as they meet the following requirements.

- Your spouse must be:
  - your legal spouse according to the laws where you live and
  - under age 70.

Domestic Partners and Non-Spouse Adults Not Eligible

The corporation's life and accident insurance plans are provided under insurance contracts that must be approved by and filed with state insurance commissions. Coverage is not available for domestic partners or for any other adult family members—except for your spouse—because these contracts govern coverage eligibility.

Dependent Children

Your children can be enrolled for accident insurance coverage, provided that they satisfy the requirements below that define who is considered your child and whether those children are considered dependents.

If you are an eligible employee, you can enroll your eligible dependent children. Eligible children include children:

- by birth,
- by adoption (effective as of the date the child is placed for adoption),
- stepchildren, and
- children for whom you are legally responsible.

Eligible dependent children include your children (as defined above) who:

- are under age 23,
- are not married,
- are not employed on a full-time basis,
- are dependent on you for financial support, and
- either:
  - live with you, or
  - are away at school.

Disabled Dependent Children

If your child becomes totally and permanently disabled before age 23, that child is eligible for coverage as your dependent as long as:

- the child is not married,
- the child is living with you,
- the child remains disabled, and
- the child is dependent on you for financial support.

To cover disabled dependent children, you must verify in writing that the disability occurred before age 23. You have 31 days from the child's 23rd birthday to provide this verification.

Naming a Beneficiary

In the case of a covered accidental injury, the covered person is automatically the beneficiary. However, you must name a beneficiary for AD&D benefits to be distributed in the case of an accidental death.

Your Beneficiary

Unless you choose otherwise, the beneficiary for your basic life insurance coverage automatically becomes your beneficiary for your AD&D insurance.

The beneficiary on record can be changed at any time on Employee Self-Service. Employee Self-Service is accessible only from The McGraw-Hill Companies Intranet. You can reach Employee Self-Service through a link on the Intranet homepage.

Your beneficiary designation must be on file with the HRSC at the time of your death for your beneficiary to receive benefits.

If you do not name a beneficiary for your AD&D coverage, benefits are paid to your first surviving beneficiary, as follows:

- Spouse
- Children
- Parents
- Siblings
- Estate

Your Spouse and Children's Beneficiaries

Your spouse may name anyone as beneficiary for spousal AD&D insurance death benefits and you may name anyone as beneficiary for children's AD&D insurance death benefits.

If no beneficiary is named, you are automatically the beneficiary for spousal and children's AD&D insurance benefits in the event of their death.

Paying for Coverage

Your Costs

You can find out the exact cost of the different coverage options available to you by accessing Employee Self-Service. Employee Self-Service is accessible only from The McGraw-Hill Companies Intranet. From the Intranet homepage, go to Top Sites and click the button that says "Employee Self-Service."

You pay for AD&D coverage through after-tax payroll deductions. Contributions for AD&D insurance coverage begin after your coverage goes into effect.

The cost for any AD&D insurance you elect is based on the amount of AD&D insurance coverage that you choose.

The number of dependent children you have does not affect the cost of children's AD&D insurance—the cost is based only on the amount of children's AD&D coverage you choose. The contributions you pay provide AD&D insurance coverage for all your eligible dependent children regardless of how many children you have.

Contributions When Not on Payroll

If you are eligible to continue participating in a corporation plan when you are not an active employee, you must make arrangements to pay any required contributions to the corporation directly. Before you go on inactive status, call the HRSC to discuss your options and make appropriate arrangements.

Depending on the reason why you are not active, your payment options may include:

- prepaying contributions, through an after-tax deduction from your final paycheck(s) before you become inactive,
- prepaying contributions on an after-tax basis with a direct payment to the corporation, or
- paying your contributions on an installment basis, after taxes, according to a schedule that would be worked out by the HRSC before you become inactive.

When Coverage Begins

The date when your AD&D coverage begins depends on when you enroll:

- As a new employee who meets the eligibility requirements, coverage begins the first day you are actively at work, provided you enroll within 31 days of the date you are hired.
- As a newly eligible employee, coverage begins as of the day you meet the eligibility requirements, provided you enroll within 31 days of becoming eligible.
  - If you enroll for coverage during the annual enrollment period, the coverage you choose during enrollment begins the following January 1.
  - If you enroll for coverage at any other time, your coverage begins the first day of the month that follows the day the HRSC receives your application.
  - If you are not actively at work on the day your AD&D coverage is supposed to begin, coverage begins when you return to active status.

Your Family Members

If you enroll your spouse or eligible children at the same time that you enroll, their coverage begins when your coverage begins.

If you enroll your eligible family members at a later time, the date when their coverage begins depends on whether you enroll them during the annual enrollment period:

- If you enroll an eligible family member for coverage during the annual enrollment period, coverage begins the following January 1.
- If you enroll an eligible family member for coverage at any time other than the annual enrollment period, coverage begins the first day of the month that follows the day the HRSC receives your application.

How Benefits Are Paid

AD&D benefits are usually paid in one lump sum, but installments can also be arranged. AD&D benefits are payable in addition to any life and travel accident insurance benefits.

In the event of a covered death, AD&D benefits are paid to the beneficiary on record. AD&D death benefits are payable in addition to any life and travel accident insurance death benefits. Children's accidental injury benefits are paid to you.

If the same accident causes more than one of the losses shown under "Amount of Your Benefit," the insurance company will pay only one amount, but it will be the largest amount that applies.

Amount of Your Benefit

The plan pays the full benefit amount in case of accidental death. (This is known as the plan's "death benefit.") Partial benefits are paid for an accidental dismemberment. Benefits are paid if the death or dismemberment occurs within 365 days of, and as a result of, an accident that occurs while you are covered by the plan.

In the table of benefit amounts, loss of a hand or foot means complete severance at or above the wrist or ankle. Loss of sight or hearing means total loss that cannot be recovered. Loss of speech means complete inability to communicate audibly in any degree. Loss of the thumb and index finger means severance through or above the metacarpophalangeal joints. Paralysis means loss of use, without severance, of a limb that is determined by a physician to be complete and not reversible.

If a covered accident causes...	Employee or spousal AD&D insurance pays this percentage of the full benefit amount...	Children's AD&D insurance pays this percentage of the full benefit amount...
▪ Loss of life	100%	100%
▪ Loss of two eyes, two hands, or two feet ▪ Loss of speech and hearing in both ears ▪ Total paralysis of both upper and lower limbs ▪ Loss of one hand and sight in one eye ▪ Loss of one foot and sight in one eye	100%	200%*
▪ Loss of one arm or leg	50%	150%*
▪ Loss of one eye, hand, or foot ▪ Loss of speech ▪ Loss of hearing in both ears ▪ Total paralysis of arm and leg on one side of the body ▪ Total paralysis of both legs	50%	100%
▪ Loss of thumb and index finger	25%	50%
▪ Loss of hearing in one ear	0%	33%

** This benefit is paid in case of a loss. If a dependent child dies within 90 days of a covered loss, the insurance company pays only the death benefit, up to a maximum of $20,000.*

Additional AD&D Benefits

Under certain circumstances, AD&D insurance pays additional benefits, as follows.

Seatbelt Protection

If the death of an insured person occurs from a motor vehicle accident when a properly fastened seatbelt is in use, the AD&D benefit is increased by 20%, up to a total increase amount of $50,000.

Training for Your Spouse

If you enroll for AD&D coverage for your spouse, and you die in a covered accident, your insured spouse can receive up to $7,500 toward an entire year of employment-related education, such as computer training, in an accredited school.

College for Your Children

If you enroll for AD&D coverage for your children, and you die in a covered accident, your insured dependent children enrolled in college or graduated from the 11th grade can receive an additional benefit. Your total AD&D benefit is increased by 5%, up to $10,000 a year, and is payable for as many as four consecutive years while your children are in college. If there are no eligible children, your beneficiary receives an additional $1,000.

Filing a Claim

To file a claim, notify the Human Resources Service Center (HRSC) toll-free at 1-888-THE-HRSC (1-888-843-4772). A representative will explain the benefits that are provided and what is needed to process the claim.

If you or your spouse is to receive benefits from this plan, you must file a written claim with the insurance company.

In the case of your accidental death, your manager notifies the HRSC and the HRSC contacts the beneficiary on file. Before death benefits can be paid, the insurance company must receive a certified copy of the death certificate and a written claim.

Payment is usually made within 90 days after all the proper documentation has been received.

If you are not satisfied with the outcome of a claim you have submitted for benefits, you can ask that the claim be reviewed. See "Claims Review Process" in *Rules and Regulations* for information.

What's Not Covered

AD&D benefits are not paid if death, dismemberment, or paralysis is caused by any of the following:

- An intentionally self-inflicted injury, including suicide, while sane or insane
- An accident resulting from piloting, hang-gliding, or parachuting
- The commission of a felony
- An accident that occurs while serving in the armed forces (However, injury or death that occurs while on active duty with the reserve or National Guard is covered.)
- Any act of war in the United States
- Any sickness, disease, or bodily infirmity

When Coverage Ends

Your employee AD&D insurance coverage ends on the earliest of the following dates:

- The last day of the month in which you retire or otherwise end your employment (whether voluntarily or involuntarily). If you are eligible for severance benefits under the Separation Pay Plan and you choose to receive those benefits in installments, some benefits can continue while you are receiving those installments. See "Continuing Benefits Coverage" in the section on the Separation Pay Plan in *Other Benefits*.
- The last day of the month in which you no longer meet the eligibility requirements for coverage
- The last day of the month in which you stop making the necessary contributions toward the cost of coverage
- The day the corporation discontinues the plan

- The day you die
- After 30 days of full-time active duty in any armed forces (If you are absent on reserve or National Guard active duty for training, your coverage continues.)

Your Family Members

Your family members' AD&D coverage ends on the earliest of the following dates:

- The day your coverage as an employee ends (as previously explained)
- The last day of the month in which your family member no longer meets the eligibility requirements for coverage
- The day the corporation discontinues coverage for family members under the plan. (You may be able to convert coverage.)
- The last day of the month in which you stop making the necessary contributions toward the cost of dependent coverage
- The day the covered family member dies

When a spouse's or child's eligibility ends, access Employee Self-Service so you can stop paying the required contributions for their coverage. Employee Self-Service is accessible only from The McGraw-Hill Companies Intranet. You can reach Employee Self-Service through a link on the Intranet homepage.

Canceling Coverage

You may discontinue AD&D insurance coverage for yourself, your spouse or your children at any time. You can begin this process by accessing Employee Self-Service. Your cancellation is effective the last day of the month in which the HRSC receives your request. If you discontinue AD&D insurance coverage, you may reapply for coverage at any time.

What Happens When...

If you retire, take a military leave, or otherwise end your employment, your AD&D coverage ends as described under "When Coverage Ends."

If you take an approved leave of absence for any reason other than for military service, you can continue AD&D coverage by continuing to make the required contributions.

If you cannot work because of an approved disability, your AD&D insurance coverage continues as long as you continue to make contributions.

For information on paying contributions when on an approved leave, see "Contributions When Not on Payroll" in "Paying for Coverage."

Converting Coverage

You may convert all or part of your AD&D insurance coverage to an individual policy purchased directly from the insurance company if your coverage is discontinued because:

- you terminate employment,
- you change to a regularly scheduled work week of fewer than 20 hours a week,
- you retire,
- you become ineligible for any reason other than reaching age 70, or
- the corporation discontinues the plan.

If you want to convert your coverage, you must submit a completed application form and your first premium payment to the insurance company within 31 days after the last day of the month in which your coverage is discontinued. Your premium for any converted coverage you elect is determined by the insurance company's rates.

If you die during the 31 days before your insurance is converted to an individual policy, your beneficiary receives a lump-sum payment of the amount you were entitled to convert, even if you did not apply for conversion.

To convert coverage to an individual AD&D policy, you must elect at least $25,000 and not more than $500,000 in AD&D coverage.

Spousal and Children's AD&D Coverage

You may convert spousal and/or children's AD&D insurance to an individual policy with the insurance company. (To convert coverage for your spouse, your spouse must be under age 70.) The premium for any converted coverage you elect is determined by the insurance company. To convert coverage, you must apply within 31 days after your corporation coverage ends.

Executive 24-Hour AD&D Insurance

A selected group of the corporation's executives are covered under a special 24-hour personal accidental death and dismemberment (AD&D) insurance program. This benefit is in addition to any other AD&D benefits for which you may be eligible. You are eligible for this coverage if you are at or above salary level 23 (or the equivalent). If you are eligible for this coverage, you are not eligible for coverage under the Group Travel Accident Insurance Plan's coverage for employees at or below salary level 22.

The corporation pays the full cost of this coverage.

How the Plan Works

The program's coverage is three times your annual compensation, up to a maximum of $1 million. Benefits are payable in the event of your death or dismemberment resulting from any accident occurring at any time.

Payment under this plan is in addition to any accident insurance you may have elected through the corporation's other accident insurance coverage and is in addition to the employee basic life insurance and any supplementary employee life insurance you may have elected.

Executive 24-Hour AD&D Insurance is based on annual compensation. Your annual compensation for this plan consists of your current pay plus short-term incentive compensation, overtime, and shift differential pay for the prior year.

- If you are paid on a commission or targeted income basis, your annual compensation includes your current annual rate of compensation/draw and planned additional compensation, plus overtime pay for the prior year.
- If you are a newly hired employee working on a commission-only basis, your annual compensation for these benefits is the estimated annual compensation as determined by your manager.

Your beneficiary is normally the same as the beneficiary you designated for your employee basic life insurance. The beneficiary on record can be changed at any time on Employee Self-Service. Your beneficiary designation must be on file with the HRSC at the time of your death for your beneficiary to receive benefits. Employee Self-Service is accessible only from The McGraw-Hill Companies Intranet. You can reach Employee Self-Service through a link on the Intranet homepage.

Coordination with Other Coverage

Here's an example of how the plan works with your other insurance coverage.

Your annual salary is $100,000 and you are covered for three times your salary by the Executive AD&D Plan ($300,000). You have enrolled in the corporation's voluntary Accidental Death and Dismemberment Insurance Plan for two times your salary ($200,000). You also have enrolled in the corporation's Supplementary Life Insurance Plan for two times your salary ($200,000). In the event of your death from an accident, your beneficiaries would be entitled to $800,000, calculated this way:

▪ Basic Group Term Life Insurance	$100,000
▪ Voluntary AD&D Insurance Plan	200,000
▪ Voluntary Supplementary Life Insurance	200,000
▪ Executive 24-Hour AD&D Insurance Plan	+ 300,000
▪ Total paid to beneficiaries	$800,000

Travel Accident Insurance

The corporation's Group Travel Accident Insurance Plan's travel accident coverage—which is provided automatically and at no cost to all active employees at or below salary level 22—can pay benefits if you, your spouse, or a dependent child dies or suffers certain injuries as the result of an accident that occurs while you are traveling on business for the corporation.

Different Coverage for Executives

If you are an executive at salary level 23 or above, you are not eligible for the travel accident coverage provided to employees at or below salary level 22. Instead, you have coverage under a special 24-hour personal accidental death and dismemberment (AD&D) insurance program. See "Executive 24-Hour AD&D Insurance" for more information.

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The Plan's Coverage

As an employee, your coverage under the travel accident plan is equal to five times your annual compensation, rounded to the next higher $500. The minimum coverage amount is $50,000 and the maximum is $1 million.

The coverage for your spouse equals $50,000.

The coverage for dependent children is $10,000.

All of the coverages noted above are the full benefit amount (also known as the "death benefit"). In case of a non-fatal travel accident, you may still be eligible for benefits from the plan. See "Amount of Your Benefit" for information on how much the plan might pay.

Benefits from this plan are in addition to any benefits you receive from Workers' Compensation, or from the corporation's life insurance, accidental death and dismemberment insurance, and disability plans.

Your annual compensation for this plan consists of your current pay plus short-term incentive compensation, overtime, and shift differential pay for the prior year.

- If you are paid on a commission or targeted income basis, your annual compensation includes your current annual rate of compensation/draw and planned additional compensation, plus overtime pay for the prior year.

Changes in Annual Compensation

If your annual compensation increases during the year, your travel accident coverage also increases, up to the $1 million maximum amount allowed. If your annual compensation decreases, your insurance is not reduced.

Eligibility and Enrolling

Ineligible Individuals

Even if you meet the eligibility requirements, you cannot participate if you fall into one or more of the groups listed under "Individuals Not Eligible" in *Rules and Regulations*.

The corporation provides travel accident insurance for all active employees at or below salary level 22, including full-time and part-time employees.

Your Family's Coverage

The plan includes coverage for your spouse and your eligible dependent children who are covered under any corporation healthcare plans, if they travel with you on a covered business trip. The plan does not cover domestic partners or adult family members other than your spouse.

Enrolling

There is no need to enroll for this plan; participation is automatic and coverage begins on your first day as an active employee of the corporation.

The corporation pays the entire cost of your travel accident insurance. The corporation will not reimburse you for any additional personal accident or disability insurance you may purchase, such as an accident policy purchased at an airport.

Although you do not need to enroll or take any other action to participate in the plan, you should name a beneficiary.

Naming a Beneficiary

You can begin the process to change your beneficiary...

at any time on Employee Self-Service.

Unless you choose otherwise, your employee basic life insurance beneficiary automatically becomes your beneficiary for travel accident insurance. If you do not name a beneficiary for either the travel accident insurance or basic life insurance, benefits are paid to your first surviving relatives or to your estate, as follows:

- Spouse
- Children
- Parents
- Siblings
- Estate

The beneficiary on record can be changed at any time by accessing Employee Self-Service. Employee Self-Service is accessible only from The McGraw-Hill Companies Intranet. You can reach Employee Self-Service through a link on the Intranet homepage.

How Benefits Are Paid

Travel accident benefits are usually paid in one lump sum, but installments can also be arranged. Benefits are payable in addition to any other life and accident insurance benefits.

In the event of a covered death, benefits are paid to the beneficiary on record. For covered injuries, travel accident benefits are paid to the person who is covered by the insurance.

If the same accident causes more than one of the losses shown under "Amount of Your Benefit," the insurance company will pay only one amount, but it will be the largest amount that applies.

Amount of Your Benefit

The plan pays the full benefit amount (also known as the "death benefit") in case of accidental death or certain covered losses while traveling on business for the corporation. A percentage of the death benefit can be paid for a dismemberment. Benefits are paid if death or dismemberment occurs within 365 days of, and as a result of, an accident that occurs while you are covered by the plan and traveling on business for the corporation.

If a covered accident causes...	The plan pays this percentage of the full benefit amount (the "death benefit")...
▪ Loss of life ▪ Combination of loss of any two: hand, foot, or eye ▪ Loss of two eyes, two hands, or two feet ▪ Loss of speech and hearing in both ears	100%
▪ Loss of one eye, hand, or foot ▪ Loss of speech ▪ Loss of hearing in both ears	50%
▪ Loss of thumb and index finger of the same hand	25%

In the table above, loss of a hand or foot means complete severance at or above the wrist or ankle. Loss of sight means permanent loss of entire sight in one or both eyes. Loss of speech and hearing means complete and irrecoverable loss. Loss of the thumb and index finger means severance through or above the metacarpophalangeal joints.

If you are permanently and totally disabled from a covered accident, you may receive the full benefit, subject to the minimum and maximum limits, if

- the disability begins within 180 days of the accident and you are totally disabled for 12 straight months, and
- you are unable to engage in any occupation, for the rest of your life, for which you are qualified through training, education, or experience.

Seat Belt Benefits

The plan provides additional benefits if you die as a result of a covered automobile accident while you are driving or riding in a private passenger car on corporation business and were wearing a properly fastened seat belt at the time of the accident. (The position of the seat belt must be confirmed in an official report of the accident or by the investigating officer.)

The additional benefit payable is equal to 20% of the full benefit amount under the travel accident plan, up to a maximum additional benefit of $50,000. If you die as a result of a covered automobile accident as described above and the car is equipped with seat belts but it cannot be confirmed that your seat belt was properly fastened, the plan will pay an additional benefit of $1,000, rather than the additional benefit of 20% of the full benefit amount.

Evacuation and Repatriation

If you suffer an injury or sickness while traveling on corporation business outside the United States, the plan will pay up to $50,000 to cover the cost of your emergency medical evacuation. To qualify for this benefit, an attending doctor must confirm that it is medically necessary for you to be evacuated under a doctor's care.

If you die while traveling on corporation business more than 100 miles from your primary residence or outside the United States, the plan will pay up to $10,000 in benefits to cover the cost of returning your remains to your home.

Air Travel Limits

The total maximum benefit provided under the plan for any one air travel accident is $7.5 million, no matter how many persons covered by the corporation's plan are involved. The maximum payment of $7.5 million will be distributed proportionately among the persons entitled to receive benefits.

What's Covered

Is traveling to and from work covered?

No. Regular commuting to and from work is not covered.

You are covered for losses incurred:

- during any business trip you make for the corporation,
- during air travel for business purposes while you are a passenger on aircraft, including helicopters and chartered planes, certified by the Federal Aviation Agency (Certain limitations apply to passenger coverage; these are described under "What's Not Covered."),
- during any acts of war, declared or undeclared, occurring outside the United States while you are on business for the corporation,
- as a result of hijacking, air piracy, or any unlawful seizure or attempted seizure of an aircraft in which you are traveling on corporation business,
- as a result of terrorism occurring inside the United States while traveling on corporation business,
- as a result of a felonious assault against you while traveling on corporation business,
- as a result of a robbery or a common law or statutory larceny, theft, or hijacking of the property of the corporation,
- while on the corporation's premises, acting as a member of a team or squad organized by the corporation to investigate a potential bomb threat.

Your spouse and eligible dependent children are covered while accompanying you on a business trip or on a relocation trip, if the trip is at the expense of the corporation and is approved by authorized department management.

Coverage for a business trip begins when you leave home or your place of regular employment, whichever occurs last; it ends when you return home or to your place of regular employment, whichever occurs first.

What's Not Covered

Benefits are not paid for deaths caused by illness or disease, or for:

- accidents during regular commuting to and from work,
- accidents that occur while acting as a pilot, crew member, or passenger in any aircraft being used for test or experimental purposes (except if you are on assignment for *Aviation Week & Space Technology* magazine),

- accidents that occur while acting as a pilot or crew member of any aircraft except aircraft owned by the corporation,
- accidents that occur while being a passenger in any aircraft owned or operated by another employee who is insured under this plan, or in any aircraft owned or operated by any member of the other employee's household,
- any bacterial infections other than those occurring as the result of an accidental cut or wound,
- accidents that occur while on full-time service in the armed forces of any country,
- accidents that occur while you are a passenger in any military aircraft other than transport-type aircraft operated by the Military Air Command (MAC) or similar air transport service of any other country,
- suicide, attempted suicide, or self-inflicted injuries, or
- accidents that occur while you are in any aircraft that is being used for fire fighting, pipeline, or power line inspection, aerial photography, or exploration.

When Coverage Ends

Travel accident insurance coverage ends on the earliest of the following dates:

- The last day of your active employment (whether terminated voluntarily or involuntarily)
- The day the corporation discontinues the plan
- The day you begin an approved leave of absence. (Coverage automatically resumes the day you return to work from your leave.)
- The day you die

Your Family Members

Your covered family members' coverage ends on the earliest of the following dates:

- The day your coverage as an employee ends (as previously explained)
- The last day of the month in which your family member no longer meets the eligibility requirements for coverage, as explained under "Eligibility and Enrolling"
- The day the corporation discontinues coverage for family members under the plan
- The day the covered family member dies

No Conversion of Coverage

Because travel accident coverage is for business travel for the corporation, it cannot be converted to an individual policy when your employment ends.

When You Leave the Corporation

If you retire or otherwise end your employment, your travel accident coverage ends on the last day of your active employment.

If you take a leave of absence, coverage is suspended for the duration of your leave and resumes automatically on the day you return to active work.

Filing a Claim

To file a claim, notify the HRSC. A representative will explain the benefits that are provided and what is needed to process the claim. If you or your spouse is to receive benefits from this plan, you must file a written claim with the insurance company. Before death benefits can be paid, the insurance company must receive a certified copy of the death certificate and a written claim.

In the case of your death, your manager notifies the HRSC and the HRSC contacts the beneficiary on file.

Payment is usually made within 90 days after all the proper documentation has been received.

Retirement Benefits

The retirement program of The McGraw Hill Companies, Inc. and Its Subsidiaries consists of three major plans:

- The 401(k) Savings Plan (SIP)
- The Profit Sharing Plan (ERAP)
- The Pension Plan (ERP)

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Terms to Know

The following are some key terms you should be familiar with as you read about the retirement plans. It is important to note that these terms have special definitions when used with the plans.

Active Employee

For benefits eligibility purposes, you are considered an active employee if you are receiving a regular paycheck (directly from the corporation) to pay wages for services you are currently providing to the corporation.

Beneficiary

For the pension plan, if you choose to have your pension benefits paid in the form of a Term Certain and Life Annuity or a Joint and Survivor Annuity, you will have to name a person to receive benefits after your death. The person you name is your beneficiary. You also need to name a beneficiary under the pension plan to receive a survivor's benefit.

A beneficiary should also be named to receive your accounts under the 401(k) savings and profit sharing plans.

Generally, if you choose someone other than your spouse to be your beneficiary, you must have your spouse's notarized consent.

Continuous Service—Retirement Program

For the purposes of calculating benefits under the retirement program, a year of continuous service is a period of 12 consecutive months—beginning on your date of employment (or the anniversary of your employment date)—in which you work at least 1,000 hours. (Special rules may apply if you joined the corporation through a merger, acquisition, or other organizational transaction.)

To determine whether you have a break in service for retirement program benefits, time during an approved leave of absence is counted as continuous service, not as a break in service.

Counting Hours

To determine how many hours you have worked, the corporation uses the following rules:

- If you are a nonexempt employee as defined under the terms of the Fair Labor Standards Act, you receive credit of one hour
  - for every hour that you work and
  - for every hour when you do not work but are approved to receive pay by the corporation (for example, an hour of paid vacation).
- If you are an exempt employee as defined under the terms of the Fair Labor Standards Act, you receive credit of 190 hours
  - for each month during which you work at least one hour, and
  - for each month when you do not work but are approved to receive pay by the corporation (for example, when you receive pay from the corporation during your vacation).

Years Not Counted

For the pension plan (ERP) only, continuous service does not include any service you had before July 1, 1986 during which you were eligible for but chose not to participate in the plan.

Breaks in Service

If you work 500 hours or less in any period of 12 consecutive months beginning with the anniversary of your employment (and you have ended your employment with the corporation), a break in service occurs.

However, a break in service does not occur if you have not ended your employment with the corporation and if the reason you worked 500 hours or less was that you were on a leave because of

- your pregnancy,
- the birth of your child,
- your adoption of a child, or
- caring for your child after birth or adoption.

In any of the preceding cases, you can receive up to 500 hours of service credit, counted in either the year the leave begins or the following year.

If Your Employments Ends and You Are Rehired

If your corporation employment ends and you are later rehired, the period between your termination and your re-employment may result in a break in service (because you may have worked 500 hours or less in the 12 consecutive months following the anniversary of your employment). Please see the description of how continuous service is treated for each of the Retirement Program plans.

Eligible Pay

Eligible pay includes compensation you receive from the corporation, such as base salary, commissions, overtime pay, short-term incentive compensation, shift differential pay, and any tax-deferred contributions you may make to pay for healthcare coverage or to the Healthcare or Dependent Care Flexible Spending Account, the Transportation Benefits Program, and the 401(k) savings plan.

If you are temporarily disabled, the amount of your benefit from the corporation Short-Term Disability Plan is included in the eligible pay on which the corporation's contribution to your pension plan benefit is based.

Highly Compensated Employee

For plans subject to federal regulations, Internal Revenue Code (IRC) rules define certain employees as "highly compensated." Employees determined to be highly compensated may be subject to special rules that affect their benefits. If your benefits are affected because you are determined to be highly compensated, you will be notified.

To determine whether an employee is highly compensated for the current year, the IRC rules look back at the prior year's compensation.

For your 2004 benefits, you are considered to be a highly compensated employee if your compensation was more than $90,000 in 2003.

401(k) Savings Plan

For information on your plan participation...

Visit HR Solutions Access through The McGraw-Hill Companies intranet or on the Internet at www2.benefitsweb.com (registration required) or call HR Solutions Access at 1-800-358-3802.

The corporation's 401(k) savings plan, the Savings Incentive Plan of The McGraw-Hill Companies, Inc. and Its Subsidiaries (SIP), makes it easy to save for your retirement through payroll deductions. The plan includes generous contributions from the corporation that match your own tax-deferred savings. In addition, with the plan's tax-deferred contribution feature and the tax-deferred growth of your earnings, you benefit from tax advantages that can accelerate the growth of your "nest egg" and reduce the income tax you pay. You control how your savings and the corporation's match are invested, choosing from 10 investment options.

In This Section **See Page**

Eligibility and Enrolling

You are eligible to begin participating in the Savings Incentive Plan (SIP), the corporation's 401(k) savings plan, as soon as you begin working if you are an active employee working in the United States or are an active U.S. employee temporarily working abroad.

Ineligible Individuals

Enrolling

When you become eligible, you are automatically enrolled in the 401(k) savings plan. Contributions equal to 3% of your eligible pay will be deducted from your pay approximately 60 days after your hire date and will be invested in the Retirement Asset Fund III, a hybrid fund that emphasizes dividend and interest income, but also offers the opportunity for long-term capital appreciation. You can change your contribution rate and your investment choices at any time—you have 10 different investment options from which to choose.

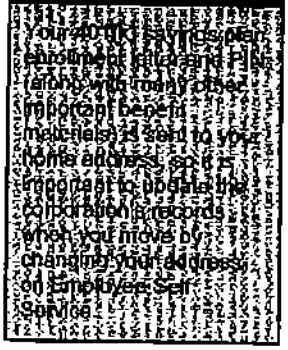
If you do not wish to participate in the 401(k) savings plan, you must contact HR Solutions @ccess and change the 3% contribution rate to 0%.

To change the percentage of pay you want to contribute and how you want your savings to be invested, visit HR Solutions @ccess through The McGraw-Hill Companies Intranet or on the Internet at *www2.benefitsweb.com/mgh.html*, or call HR Solutions @ccess at 1-800-358-3603.

If you lose or forget your Personal Identification Number (PIN), visit HR Solutions @ccess online or call HR Solutions @ccess. You can request that a PIN reminder be sent to you at your home address. Please keep in mind that it may take three to five business days for you to receive a replacement PIN. You'll need your PIN to transact 401(k) savings plan business or to obtain information about your participation in the plan through HR Solutions @ccess.

For more information on changing your contributions, see "Changing Your Contributions" under "Employee Contributions."

Update Your Home Address



Naming a Beneficiary

As part of enrolling, you need to name a beneficiary, or beneficiaries, to receive your plan balance if you die.

You may name anyone as your beneficiary. However, if you are married, your spouse is automatically your beneficiary. To name someone other than your spouse, you must have your spouse's notarized consent. If you name a beneficiary and are later married, your new spouse automatically becomes your beneficiary unless you have your spouse's notarized consent to name someone else.

A beneficiary designation form will be included in your enrollment packet. The designation form must be on file with the corporation on the date of your death for the designation to be effective.

If you die without having named a beneficiary, your benefit is automatically paid in the following order:

- To your surviving spouse
- To your surviving children
- To your surviving parents
- To your surviving siblings
- To your estate

Changing Your Beneficiary

You may change your beneficiary at any time by completing and submitting a new form. To change your beneficiary, visit HR Solutions @ccess through The McGraw-Hill Companies Intranet or on the Internet at *www2.benefitsweb.com/mgh.html*, or call HR Solutions @ccess at 1-800-358-3603. If you are married, remember that you need your spouse's notarized consent to name anyone other than your spouse as your beneficiary.

How the Plan Works

You Control the Investment

You control how your assets in the plan are invested. The value of your benefits will depend on how the investments you choose perform. Benefits are not guaranteed or insured (in contrast to the way pension plan benefits are insured by the Pension Benefit Guaranty Corporation).

The corporation's 401(k) savings plan, the Savings Incentive Plan (SIP) makes it easy to save for your retirement through payroll deductions. The plan includes generous contributions from the corporation that match your own tax-deferred savings. In addition, with the plan's tax-deferred contribution feature and the tax-deferred growth of your earnings, you benefit from tax advantages that can accelerate the growth of your "nest egg" and reduce the income tax you pay.

You control how your savings and the corporation's match are invested, choosing from 10 investment options. You choose from the same investment options offered for the profit sharing plan, and the investment choices you make apply to the contributions made to both plans. See *Investment Options* for more information.

Tools for Managing Your 401(k) Savings Plan

The 401(k) savings plan features tools that help you track your savings and get the information you need to make informed investment decisions. The tools include annual statements and automated online and telephone systems.

Annual statements—Each year you receive a statement that provides:

- your account balance,
- details on any transactions since the previous statement,
- contributions made during the year (both yours and the corporation's),
- your vesting status,
- investment earnings or losses in your account, and
- information on how each of the investment funds performed for the year.

Automated systems—HR Solutions @ccess, an Internet Web site and its interactive telephone system, makes it easy for you to:

- enroll in the plan,
- get your current account balances,
- change your contribution rate,
- change your investment choices,
- track the investment funds' performance,
- request a hardship withdrawal or hardship loan application,
- try out different repayment options before taking a hardship loan,
- access computer-generated projections of your account balances, and
- view a quarterly statement online.

You can reach HR Solutions @ccess through The McGraw-Hill Companies Intranet or on the Internet at *www2.benefitsweb.com/mgh.html*.

You can reach HR Solutions @ccess toll-free at 1-800-358-3603 from any touch-tone telephone. You can call HR Solutions @ccess at any hour, seven days a week. HR Solutions @ccess Account Representatives are available Monday through Friday, between 9:00 a.m. and 5:00 p.m., Eastern Time. The HR Solutions @ccess User Guide can help you through the steps needed to complete your call. Call HR Solutions @ccess to request a User Guide.

In both cases, you'll need your Social Security number and Personal Identification Number (PIN). If you don't know your PIN, you can request a PIN reminder through HR Solutions @ccess online or by calling HR Solutions @ccess.

Employee Contributions

Your contributions to the 401(k) savings plan are based on percentages of your eligible pay. You can contribute any whole percentage (1%, 2%, etc.)—between 1% and 25%—of your eligible pay, subject to Internal Revenue Service (IRS) limits, including the Elective Deferral Limit. See "Savings Limits" for details.

Contributions are deducted from your pay each pay period. For most employees, there are only two kinds of payroll contributions—tax-deferred contributions and after-tax contributions. For employees age 50 or older, there is an additional, new kind of payroll contribution—catch-up contributions.

In addition to payroll contributions, you are also permitted to make two kinds of contributions that are not deducted from your pay:

- Lump-sum contributions (after-tax only)
- Rollover contributions

All of your contributions and the corporation's contributions are credited to the plan twice a month, consistent with the corporation's standard payroll schedule. Once the money is in the trust, only you can control how it is invested and only you can withdraw the money if your employment with the corporation ends and, in some cases, during employment.

Payroll Contributions

Employees participating in the plan may contribute up to 25% of their eligible pay. You can divide this 25% maximum between both tax-deferred and after-tax payroll contributions. For example, you could choose to contribute 10% of your eligible pay, and split that 10% into 7% tax-deferred contributions and 3% after-tax contributions.

Only the first 6% of your tax-deferred contributions are eligible for corporation matching contributions. If you contribute more than 6% tax-deferred, no corporation matching contributions will be paid on your tax-deferred contributions that exceed 6% of your pay.

Lump-Sum After-Tax Contributions

The following restrictions apply to lump-sum contributions:

- Lump-sum contributions may be made only on an after-tax basis. Tax-deferred lump-sum contributions are not permitted.
- You may make lump-sum contributions at any time during the calendar year before December 1. Lump-sum contributions are not permitted during December.
- The total of your payroll contributions (both tax-deferred and after-tax) and your after-tax lump-sum contributions cannot be greater than 25% of your eligible pay for the calendar year in which the contributions are made.

If you want to make a lump-sum contribution, visit HR Solutions @ccess or call HR Solutions @ccess to request a form, and follow the instructions on the form.

Catch-Up Contributions

401(k) participants who will be age 50 or older in 2004 are eligible to make additional pre-tax contributions to their 401(k) accounts—"catch-up" contributions. As the name implies, catch-up contributions enable older participants to save more, so that their savings can catch-up with their retirement needs. The intent is to provide enhanced savings opportunities to individuals who may not have had access to 401(k) plans throughout their careers.

If you are eligible and your regular pre-tax contributions will reach the current maximum plan contribution limit, you can contribute more than the limit would normally allow, up to a separate annual catch-up contribution maximum. There is no company match for catch-up contributions.

Your catch-up contributions will be invested with your regular 401(k) contributions.

Eligibility

To be eligible to make a catch-up contribution to your 401(k) account, you must be age 50 or older in the plan year in which the catch-up contribution is made. For the 401(k) plan, the "plan year" is the same as the calendar year—it begins January 1 and ends December 31. So, to be eligible to make catch-up contributions in 2004, you must be age 50 or older by December 31, 2004.

Catch-Up Contribution Limits

For 2004, the most you can save as catch-up contributions is $3,000. This is in addition to the regular Elective Deferral Limit on pre-tax contributions, which is $13,000 for 2004.

Catch-up contribution limits are scheduled to increase by $1,000 each year through 2006, along with the scheduled increase in the Elective Deferral Limit. This means that in 2006, the maximum amount eligible individuals will be able to defer will be $15,000 in regular pre-tax contributions plus $5,000 as additional catch-up contributions, for a total pre-tax contribution of $20,000. The amount an individual can actually contribute to the plan is a function of eligible compensation and plan limits.

Year	Pre-tax Contribution Limit ("Elective Deferral Limit")	Catch-up Contribution Limit	Total Pre-tax Contribution Limit
2004	$13,000	$3,000	$16,000
2005	$14,000	$4,000	$18,000
2006	$15,000	$5,000	$20,000

Catch Up As Much As You Want

You do not need to make the full $3,000 catch-up contribution for 2004. You can elect to make a lower catch-up contribution by electing a different catch-up contribution amount.

Specifying Your Catch-Up Contribution Amount

Your catch-up contribution election is expressed as a dollar amount per pay period, rather than as a percentage of your pay.

Catch-up contributions are deducted from your pay before income tax withholding is calculated, the same as your regular pre-tax contributions. Remember that your catch-up contributions will be in addition to your regular 401(k) pre-tax contributions.

Depending on the contribution amount you elect, your catch-up contributions will continue until you change your catch-up contribution election or you reach the annual catch-up contribution limit. For example, if you elect a catch-up contribution of $150 per semi-monthly pay period, your catch-up contributions will reach the $3,000 annual limit for 2004 in 20 pay periods.

The catch-up contribution amount you elect for 2004 will remain in effect when 2005 begins unless you make a catch-up contribution change between November 15 and December 15, 2004. You can make a change in your catch-up amount after December 15, 2004, but that change won't be effective until after 2005 payroll deductions begin. Be sure you understand how this may affect you. To continue the example above, if you have elected a $150 catch-up contribution and reached the $3,000 limit late in 2004, the $150 catch-up contribution will be in effect at the start of 2005, and deductions to make the contributions will resume at that point.

If Your Pre-Tax Contributions Don't Reach the Limit

Rules governing catch-up contributions require that participants make the maximum 401(k) contribution allowed by the plan to make catch-up contributions. At year-end, the recordkeeper will review all participants' 401(k) contribution elections and catch-up contribution elections. If your regular, pre-tax contributions do not equal the maximum contribution allowed ($12,000 for 2004), your catch-up contributions will be reclassified as regular 401(k) contributions.

To Make 2004 Catch-Up Contributions

If you are interested in making a catch-up contribution, you'll need to make a separate contribution election through HR Solutions @ccess via the Intranet or through the Internet at *www2.benefitsweb.com/mgh.html*. To make a catch-up contribution election, access HR Solutions @ccess online and use the 401(k) savings link, then choose "transactions" and then "contribution rate."

You can also make your catch-up contribution election through HR Solution @ccess's Voice Response System at 1-800-358-3603.

Rollovers

If you are eligible to receive a distribution from a prior employer's tax-favored retirement plan, you can elect to roll over some or all of the distribution into the 401(k) savings plan. To arrange a rollover, visit HR Solutions @ccess on The McGraw-Hill Companies Intranet or at *www2.benefitsweb.com/mgh.html*, or call HR Solutions @ccess at 1-800-358-3603.

You can make a rollover contribution to the 401(k) savings plan even if you elect not to make payroll contributions. If you make such a rollover, your savings will still continue to grow on a tax-deferred basis.

If you are considering making a rollover contribution, be sure that you understand how the McGraw-Hill plan works—for example, you should know how McGraw-Hill's loan and withdrawal provisions differ from those of your previous employer.

Your Rollover Contribution Options

If you have savings from a previous employer's tax-favored retirement plan, you generally have four options:

- Roll over your balance into the corporation's 401(k) savings plan.
- Roll over your balance into an Individual Retirement Account (IRA).
- Keep your balance in your prior employer's plan. (This option may not be available—check with your previous employer.)
- Take a distribution of your savings. (Tax penalties may apply.)

Participating at a Later Date

If you do not elect to participate when first eligible, you can resume contributions at any later date. However, you must do so no later than 4:00 p.m., Eastern Time, on the 15th of the month for your participation to begin as of the first pay period of the following month.

- Transactions entered by 4 p.m. on the 15th of the month will be effective the first of the following month and will be reflected in the first semi-monthly payroll of the month.
- Transactions entered after 4 p.m. on the 15th of the month and before 4 p.m. on the last day of the month will be effective the 16th of the month following and reflected in the second semi-monthly payroll of the month.

If you are paid weekly, your contributions will be effective with your weekly payroll closest to the 15th or the last day of the month. In some cases, depending on the dates of your weekly payroll, there may be a delay of up to three weeks before your contributions become effective.

The Cost of Waiting

Justine, a 30-year-old making $30,000 a year, decides to save 6% of her pay in the 401(k) savings plan. This chart shows how much more money Justine will have in her 401(k) savings plan account at age 65 because she starts saving today, instead of 3, 5, 7, or 10 years from today.

If Justine Begins Saving at...	Her Savings Will Be...
Age 30	$761,636
Age 33	$586,771
Age 35	$490,939
Age 37	$409,055
Age 40	$308,237

This chart is for illustrative purposes only and assumes the corporation matching contribution continues unchanged, that investments earn a return of 7% each year, Justine's salary increases by 4% each year and she does not take any hardship withdrawals or hardship loans out of her account during this period. Your actual investment return may be more or less, depending on your investment choices and the actual performance of the investment options you choose.

How Tax-Deferred and After-Tax Contributions Differ

With tax-deferred contributions, money is deducted from your pay before federal and, in most cases, state and local income taxes are calculated. In addition, any investment earnings paid on your contributions accumulate tax-free until you take your money out of the plan. See "Savings Limits" for information on plan and IRS maximums. When you withdraw your tax-deferred contributions, you pay income taxes on them at that time.

When you choose an after-tax contribution, money is deducted from your pay after applicable taxes have been deducted. Although you pay current taxes on the money you put in the plan, the earnings on this money accumulate tax-free until you take the money out. When you withdraw your after-tax contributions, you do not need to pay income taxes on them because you paid income tax before you contributed them to the plan.

Tax Deferred vs. After-Tax Savings

There's an important difference between saving tax-deferred dollars and saving after-tax dollars. Tax-deferred contributions let you save money while reducing your current income taxes. Look at this example, which assumes Sara saves 5% of her eligible pay ($30,000) through the 401(k) savings plan.

	Tax-Deferred Savings	After-Tax Savings
Sara's eligible annual pay	$30,000	$30,000
Tax-deferred savings (5%)	$1,500	$0
Sara's taxable income*	$28,500	$30,000
Federal income taxes**	$3,263	$3,488
After-tax savings (5%)	$0	$1,500
Sara's take-home pay	$25,237	$25,012
Difference	$225	

** Assumes Sara is single and has standard deductions*

*** This example is calculated using 2003 tax rates for unmarried individuals and does not show Social Security, Medicare, or state and local income taxes.*

The most important difference between saving on a tax-deferred basis instead of an after-tax basis is that Sara receives a corporation matching contribution on a percentage of her tax-deferred contributions to the 401(k) savings plan, allowing her savings to potentially grow even more.

By saving on a tax-deferred basis, Sara has $225 more in take-home pay for the year. If Sara were to earn more (or save more on a tax-deferred basis), the difference in her take-home pay might be even greater.

Changing Your Contributions

You can increase, decrease, stop, or resume contributions by visiting HR Solutions @ccess online or by calling HR Solutions @ccess.

- Transactions entered by 4 p.m. on the 15th of the month will be effective the first of the following month and will be reflected in the first semi-monthly payroll of the month.
- Transactions entered after 4 p.m. on the 15th of the month and before 4 p.m. on the last day of the month will be effective the 16th of the month following and reflected in the second semi-monthly payroll of the month.

For example, if you call HR Solutions @ccess on May 14, your change is effective with the June 1 pay period, but if you call on May 16, your change is effective with the June 16 pay period.

When you make a change, a confirmation statement describing the change is mailed to your home address.

Blackout Periods

Certain employees are restricted in trading company stock, including any transactions in The McGraw-Hill Companies Stock Fund in their 401(k) savings and profit sharing accounts, during certain periods when corporation earnings information is released. This restricted period, called the "blackout period," begins on April 1, July 1, October 1, and January 10 and runs until 24 hours after the release of the corporation's quarterly earnings.

If you are subject to this blackout period, you will be notified. During this period, you can make changes to any of your investment choices except The McGraw-Hill Companies Stock Fund.

Life Events and Your Contributions

If You Become Disabled

If you are temporarily disabled, your and the corporation's contributions to your 401(k) savings plan account continue while you are receiving benefits from the corporation's Short-Term Disability (STD) Plan.

If you are totally disabled and begin to receive benefits from the corporation's Long-Term Disability (LTD) Plan, all contributions to your 401(k) savings plan account will end. However, you will continue to be credited with continuous service for vesting purposes (to determine the vested portion of your employer contribution account attributable to contributions made prior to 2001).

If You Take an Unpaid Leave

If you take an unpaid leave of absence, your 401(k) savings plan contributions will be suspended until you return to work. You are eligible to make up contributions to the plan when you return only if your leave was covered under the Uniformed Services Reemployment Rights Act (USERRA). See "Military Leaves," below.

Military Leaves

If you return from a qualifying leave of absence for military service, you are eligible to make up contributions to the 401(k) savings plan as if you had actually received your regular eligible pay from the corporation during your leave. If you make up your missed pre-tax contributions, you will be credited with related matching contributions.

You may make up contributions through:

- payroll deductions, or
- a single lump-sum payment from your personal funds to the plan.

Contributions made through payroll deduction may be allocated between tax-deferred and after-tax contributions, subject to certain tax law limits. You will be notified if these limits apply to you.

If you choose to make up your savings through a lump-sum payment, your contributions will be on an after-tax basis.

Corporation Matching Contributions

When you save through the 401(k) savings plan, the corporation saves for you, too. The corporation matches the first 6% of your tax-deferred payroll contributions as follows:

- The first 3% of pay that you contribute is matched dollar for dollar.
- The next 3% of pay that you contribute is matched at 50¢ on the dollar.

The corporation does not match tax-deferred contributions greater than 6% of your eligible pay, nor does the corporation match after-tax contributions.

The corporation's match follows the investment of your employee contributions.

The corporation's matching contributions—and any investment earnings on them—accumulate tax-free until they are paid to you.

Compensation Limits

IRS rules do not permit compensation over the IRS Annual Compensation Limit ($205,000 in the year 2004) to be considered when calculating benefits under the plan. The Annual Compensation Limit may change each year.

If your compensation exceeds the IRS limit, you will be automatically enrolled in the supplemental plan. This plan provides benefits equal to what you would have received under the regular plan, had the limit not been in effect.

How the Corporation Match Adds Up

Corporation matching contributions can substantially increase your retirement savings, as shown in this example. Assume Matthew earns $30,000 a year and saves 8% of it ($2,400 a year) in the 401(k) savings plan. Here's how the match would affect his savings.

Matthew Saves	**$2,400**
The Corporation Match	
On the first 3% Matthew saves (100% match)	$900
On the second 3% Matthew saves (50% match)	$450
On the final 2% Matthew saves (no match)	$0
Total corporation match	$1,350
Total Savings	$3,750

As you can see, the corporation match can have a huge impact on savings. When Matthew contributes $2,400 to the 401(k) savings plan, the corporation match increases his savings to $3,750—which includes a 75% increase on the first 6% Matthew contributes. Also, keep in mind that your contributions, the corporation-matching contributions, and any investment earnings on those contributions will accumulate tax-free until they are paid to you, compounding your earnings potential even more.

Corporation Contribution Timing and Make-Up Contributions

If you're contributing to the 401(k) savings plan, it's important to understand how the IRS limits and the way the corporation-matching contributions are paid could affect when the corporation matching contributions are credited to your account.

- The IRS limit, known as the Elective Deferral Limit, on pre-tax contributions for 2004 is $13,000 (not including catch-up contributions). If your eligible pay is $52,000 or more you may reach that $13,000 limit.
- Your contributions and the corporation match are calculated and credited to your account each pay period.
- Corporation-matching contributions are credited to your account only if pre-tax payroll contributions are being made at the same time. Once your pre-tax contributions (excluding catch-up contributions) reach the Elective Deferral Limit, your pre-tax savings will stop for the rest of the year.
- If your pre-tax contributions stop because you have reached the Elective Deferral Limit before you have received the full amount of matching contributions you are eligible for, you will receive a special "make-up" matching contribution at the end of the year.
  - If you leave the corporation in the middle of the year, this make-up contribution will be pro-rated. For example, if you leave the corporation at the end of August, the make-up contribution will be adjusted so that your total corporation matching contribution will be $^{8}/_{12}^{ths}$ of the annual corporation matching amount you would have received.

Savings Limits

IRS regulations and plan rules limit the amount you can save on a tax-deferred basis each year.

Limits on Pre-Tax Contributions

Increasing Contribution Limits

2004—$13,000

2005—$14,000

2006—$15,000

In 2004, employees can save on a pre-tax basis up to the lesser of

- 25% of their eligible compensation or
- the IRS annual maximum, known as the Elective Deferral Limit, which is $13,000 for 2004.

The pre-tax Elective Deferral Limit is scheduled to increase $1,000 in each of the next few years, reaching a peak of $15,000 in 2006. Thereafter, increases in the deferral limit will be linked to inflationary increases.

Limits on Catch-Up Contributions

For 2004, if you meet the eligibility criteria for catch-up contributions, you can make an additional pre-tax contribution of up to $3,000 to your 401(k) account.

The amount you can contribute as catch-up contributions is scheduled to increase by $1,000 each year through 2006. (The amount you can contribute as regular, pre-tax contributions is also increasing each year through 2006.)

In 2006, the *maximum* amount eligible individuals will be able to defer will be $15,000 in regular pre-tax contributions plus $5,000 as additional catch-up contributions, for a total pre-tax contribution of $20,000. The amount an individual can actually contribute to the plan is a function of eligible compensation and Plan limits.

Year	Pre-tax Contribution Limit	Catch-up Contribution Limit	Total Pre-tax Contribution Limit
2004	$13,000	$3,000	$16,000
2005	$14,000	$4,000	$18,000
2006	$15,000	$5,000	$20,000

Other Contribution Limits

Contributions by some employees may also be limited by Section 415 of the Internal Revenue Code (relating to maximum contributions to and benefits from tax-favored retirement plans).

You will be notified if you are affected by such limits.

If your compensation exceeds the IRS Annual Compensation Limit ($205,000 in 2004), you will be automatically enrolled in the supplemental savings plan. This plan provides benefits that make up for those you would not receive because of the IRS limits.

When Contributions End

You cannot continue contributing to the 401(k) savings plan under these conditions:

- After your employment ends, regardless of why your employment ends.
  - If you are eligible for separation pay and elect to receive it in installments, your 401(k) savings plan contributions will not continue while you are receiving separation pay. For details, see *Severance Benefits* in the *Other Benefits* section.

- While you are receiving long-term disability benefits from the corporation's Long-Term Disability (LTD) plan.
- For six months after you've taken a hardship withdrawal, as described under "Loans and Withdrawals."

If you take a leave of absence, your contributions to the plan are suspended during your leave. However, if you return from a military leave, you are eligible to make up contributions to the 401(k) savings plan as if you had actually received your regular eligible compensation from the corporation during your leave.

Vesting

Being vested means that you own the contributions and earnings in your account.

- You are always 100% vested in your contributions and their earnings.
- You are immediately vested in any corporation matching contributions made after December 31, 2000.
- If you have corporation matching contributions in your account that were made before January 1, 2001, your vesting status will depend on how many years of continuous service you have. Once you have four years of continuous service, you are fully (100%) vested in any company matching contributions and their earnings. You continue to earn years of service during any period in which you are receiving LTD benefits. If you have less than four years of service, you vest in percentages, as follows:

Years of Service	Percentage Vested
2 but less than 3	50%
3 but less than 4	75%
4 or more	100%

If You Are Rehired

If you are rehired, any new corporation matching contributions (made after December 31, 2000) are immediately vested according to the new plan rules. However, you still may need to accumulate years of service for corporation matching contributions made before January 1, 2001, to vest, as follows:

- You always receive vesting credit for your prior service regardless of how long you were away from the corporation.
- The unvested portion of your account that you forfeited at the time of your termination will be restored whether or not you received a distribution of your vested account, if you meet the following requirements:
  - You are rehired without a break in service.
  - You are rehired with a break in service, but you were away for fewer than five years.